Clinical Instructions

For

Wisconsin's

Functional Eligibility Screen

for Children's Long-Term

Supports

Department of Health and Family Services

Bureau of Developmental Disabilities Services

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Wisconsin Children's Long-Term Support Functional Screen Clinical Instructions[1]

MODULE #1: Overview of the Children's Long-Term Support Functional Screen (CLTC-FS)

1.1 Introduction

The Wisconsin Children's Long-Term Support Functional Screen (CLTS-FS) was developed by a Department of Health and Family Services (DHFS) workgroup in 2002 – 2003, as part of Wisconsin's Children's Long-Term Support Redesign project. The goal of the redesign project has been to improve access, coordination, choice, quality, and financing of the long-term support systems to better serve children and families.

The CLTS-FS is built upon the success of Wisconsin's Long-Term Care Functional Screen (LTC FS) for adults. The LTC FS now provides virtually instantaneous eligibility determinations and specific levels of care (explained below) for over one-third of Wisconsin's adults with long-term needs (frail elders and people with physical and developmental disabilities). The LTC FS has proven extremely accurate and reliable. (For more information, see http://dhfs.wisconsin.gov/LTCare/FunctionalScreen)

The CLTS-FS has been developed using the same infrastructure as the adult screen, however the CLTS-FS functions independently of the adult screen and is more complex because:

- It must work well for children from birth through young adult (age 22 years);
- It determines eligibility for multiple programs;
- It determines multiple levels of care; and
- Specific diagnoses are required for eligibility for some programs.

Another significant difference is the development process utilized for the CLTS-FS. The CLTS-FS has been programmed as a computer application far earlier in its reliability and validity testing. Several important issues result from this:

- Screeners are testers and co-developers: As you complete the screen; you must give feedback on its function, and accuracy.
- Screeners will inform families that we are testing a new computer-based eligibility tool. The information a screener is collecting to determine eligibility in the traditional manner will also be entered into the secure database. It must be clear that the CLTS-FS does not affect or determine eligibility at this time. It must be clear that a family has the right to decline having this information used in testing without negative consequences to them.

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[1] In this document, the gender-neutral pronoun "they" is used to refer to a person. Although numerically imprecise, this is an accepted form of non-sexist language (per American Philosophical Association, 1986). "i.e." means "in other words"; "e.g." means "for example."

Even after testing of the CLTS-FS is complete, there will be a "safety net" established to ensure that no child and family are wrongfully denied eligibility. State staff will be available to help with screen questions and review questionable eligibility results.

Screen development is an "interactive" process. We will continue a quality improvement process of adjusting and fine-tuning the screen until everyone feels it works correctly for all children and families. All stakeholders' feedback is important in this process. DHFS will analyze individual screens and data, for example comparing screen eligibility to previous eligibility determinations, as part of this refinement process.

The components of the CLTS-FS are as follows:

- Basic **Child and Family Demographics**, including information about county of residence and responsibility, living situation and medical insurance;
- **Diagnoses**;
- **Mental Health and Psychiatric Symptoms**;
- **Behavioral Needs**;
- **Activities of Daily Living (ADLs)** including age appropriate skills in bathing, dressing, grooming, mobility, transfers, eating, and toileting;
- **Instrumental Activities of Daily Living (IADLs)** including**,** as appropriate for the child's age, communication, learning, meal preparation, and money management;
- **Work and School** including information about the current school/work situation as well as supports needed and interests for future employment, and;
- **Health-Related Services** including skilled nursing tasks, therapies, and other medically oriented interventions.

The CLTS-FS also includes information on risk factors, current and preferred living situations, and other factors.

The focus of the CLTS-FS workgroup was to describe the needs of children with long-term support needs living at home, in substitute care settings, or in institutions as these factors relate to functional eligibility required for various children's long-term support programs. The following are the "screen development criteria" that guided these decisions:

- **Objectivity and Reliability**: The CLTS-FS is designed to be as objective as possible in order to reach the highest possible **"inter-rater reliability"** (two screeners would answer the same way for a given child). Subjectivity is minimized to ensure fair and proper eligibility determinations, as well as to improve statewide consistency.
- **Accuracy**: Eligibility determinations must be correct and must match current accurate decisions, in **every** instance.
- **Brevity**: The CLTS-FS is only a "functional assessment" to determine program eligibility. It serves as a baseline for more in-depth assessment to develop a service plan that reflects each child's and family's strengths, values, and preferences.
- **Inclusiveness**: Children of all ages; with emotional, cognitive disabilities, physical disabilities, or developmental disabilities; with or without skilled nursing needs; in any setting from homeless to hospitals or institutions; can be accurately screened with the given choices for each question.

- **Clarity**: Definitions and answer choices, including diagnoses and nursing needs, must be clear to screeners with a broad array of professional backgrounds and experiences.

1.2 The CLTS-FS Determines Eligibility for Long-Term Support Programs

The CLTS-FS determines functional eligibility for people from birth to age 21 years inclusive, and where relevant, a specific "Level of Care," (explained below) for five different programs:

- Katie Beckett Medicaid Program
- Family Support Program
- Community Options Program
- Mental Health Wraparound Services
- Home and Community-Based Services Waivers

The Home and Community-Based Services Waivers include the following specific waivers: The Community Integration Program (CIP), and Children's Long-Term Support Waivers, also known as the new children's waivers. The Centers for Medicare and Medicaid Services (CMS) requires that "Target Groups" not be combined within one waiver. Therefore, there are three complimentary CLTS waivers (Developmental Disabilities, Physical Disabilities, and Mental Health).

The screener will collect relevant functional eligibility information in the course of meeting a child and their family. Again the CLTS-FS is not a comprehensive assessment; rather it is a review of key information related to functional eligibility. Once the CLTS-FS screen fields are complete, the computer eligibility logic is able to determine Hospital (HOS), Psychiatric Hospital (SED), Nursing Home (NH), and Developmental Disability (DD) Level of Care (LOC) for both Home and Community-Based Services Waivers, as well as the Katie Beckett Medicaid Program. Additionally, the related Target Group(s): Physical Disability, Mental Health or Developmental Disability, for the Home and Community-Based Services Waivers is determined.

Social Security Disability Determination
A child must also have a Social Security determination of disability for Katie Beckett Medicaid Program and Home and Community-Based Waivers eligibility. If a child has a confirmed disability determination the CLTS-FS will issue actual eligibility results. If the child has not had such a determination, or if their disability status is unknown, the screen will display "pending a disability determination" on the eligibility results page. Eventually, parts of this disability process may be included in the screen; however, this area is still in the development stage.

The CLTS-FS will also provide an eligibility determination for the Family Support Program, Community Options Program, and Mental Health Wraparound. The screener does not need to select which program(s) they want eligibility determined for, rather the screen will automatically review the child's needs in comparison to eligibility criteria for all programs. Eligibility results may show that a particular child is eligible for some programs but not functionally eligible for other programs.

Screeners should always confirm that the NH or DD LOC seems appropriate for the child. If a child meets the DD LOC, NH LOC results may also be displayed in some instances. If the child meets DD LOC this will typically override the NH LOC. Be sure you confirm all health-related

services with medical records, a nurse or other health professional familiar with the child. If you have questions about any of the clinical areas contact DHFS clinical consultants as necessary.

Please note: The CLTS-FS is in testing. If eligibility results do not seem appropriate to you, or if you have any questions, you must let State staff know.

1.3 Other Functions of the CLTS-FS

1. Serve as a foundation for the comprehensive assessment related to long-term supports and services selected by the parent(s).
2. Provide data for quality assurance and improvement studies for the Department of Health and Family Services (DHFS) and long-term support programs utilizing the CLTS-FS.
3. Provide data to counties and, as appropriate, to provider agencies on eligible children and on encounter data and timeliness of the eligibility process.

1.4 Process for Transferring a Functional Screen

What Certified Screener Needing Functional Screen Will Do:

1. Have the parent and child, if over 14 years of age, sign and date a lime green Release of Information (ROI) if one is not currently in the KBP record and revising the screen for a "Change in Condition" is being considered (see below). The child's name must be clearly and correctly spelled on the form, include his/her date of birth and Identification Number (the child's Social Security number).

2. FAX the completed ROI to the attention of the Katie Beckett Program Assistant at 608-261-6752.

What the Katie Beckett Program Assistant Will Do:

1. The Katie Beckett Program Assistant checks the master roster of Certified Functional Screeners. If the person requesting the screen transfer is on the list, she will electronically make the transfer as soon as possible. A Katie Beckett Consultant can't use the "Change in Condition" button unless the existing screen is transferred. All other buttons can be used and a transfer is not required to proceed.

2. The Katie Beckett Program Assistant will also e-mail the screener who originally completed the Functional Screen being transferred and give them the name of the child and name of screener receiving the Functional Screen. That person may decide whether or not to contact the receiving screener and discuss any issue that might be pertinent regarding how they completed the FS.

3. Only a **completed screen** where eligibility has been calculated can be transferred.

What the Person Receiving the Functional Screen Will Do:

1. The person receiving the screen must check that the correct child's screen was transferred plus the completion date for the most recent Functional Screen.

2. If the most recent screen *is less than six months old*, the screener reviews the entire transferred screen by selecting the "**View**" button to confirm that the screen remains accurate. If the screen does not need updating, the eligibility results of the transferred screen can be used.

   If there has been a significant change in the child's *medical condition*, the screener should select the "**Change in Condition**" button and make the corresponding modifications. The "Change in Condition" button can only be used by the screener who created the screen being viewed unless the screen has been transferred. If there has been a change in the child's *non-medical condition*, such as the child's demographic information or functioning, the screener should select the "**Edit**" button and update the screen. All previous screens will be saved.

3. If the most recent screen *is between six to twelve months old*, the screener should automatically update the screen using the "**Edit**" button. Using this button will force the screener to enter a new screen start date.

4. If the most recent screen *is over twelve months old*, a new screen needs to be completed using the "**Annual Rescreen**" button.

1.5 Requirements for Quality Assurance and Screener Qualifications

As discussed above, the CLTS-FS determines a child's eligibility for Wisconsin's long-term support programs, including Katie Beckett Medicaid Program, Family Support Program, Community Options Program, Mental Health Wraparound Services, and Home and Community-Based Services Waivers. Special requirements for quality assurance and screener qualifications are necessary because the CLTS-FS determines program eligibility. The screener must have experience regarding the unique needs of children with significant disabilities. The screener must also complete training to be a certified screener, as well as on-going review of their reliability as a screener.

1.6 Screen Quality

Parallel to the screener qualification, training, and certification requirements stated above, there are quality performance and assurance requirements to ensure consistency and accuracy of administration of the screen. There are three levels of CLTS-FS quality assurance.

1. **Individual Screener Quality Assurance**. It is the screener's responsibility to be objective in screening, to be informed of the instructions, and to corroborate information gathered from the child's family. The State clinical staff can address questions that arise.

2. **Agency Level Screen Lead Quality Assurance Review**. The methods each agency will be conducting will, at a minimum, include:
   - Inter-rater reliability testing;
   - Training, mentoring, and monitoring new screeners;
   - Random sampling for accuracy and consistency;
   - Completing reports; and
   - Consulting with State clinical staff.

3. **State Level Quality Assurance Review**. Department of Health and Family Services will review screens and utilize quality assurance methods during quarterly and annual reviews. This will include a series of analyses and comparisons of all agencies' screens. Each agency will receive a report following such reviews, including a request to the screening agency to correct and amend screen errors.

1.7 The CLTS-FS is Voluntary

The CLTS-FS is only in the testing phase at this time. Parent(s) should be fully informed of this, and informed that their participation is completely voluntary. Parent(s) should be assured that participation or refusal to participate in screen testing has no impact on the child's eligibility. Eligibility will be determined in the usual fashion until the screen is finalized. The parent(s) should also be informed that information gathered during the screening process is confidential, and that information will be submitted to DHFS for aggregate data analyses. No screen should be completed without the parent(s) consent.

Screening agencies shall comply with confidentiality rules and requirements and shall obtain a signed release of information from the child's parent or guardian for the use of medical records, educational records and other records as appropriate before conducting the Children's Functional Screen. Signed releases of information shall be included in the child's records when appropriate.

1.8 Confidentiality

Any information collected for the screen or during the screening process is confidential. Information is to be treated with the same requirements for confidentiality within the current system of long-term supports. If one agency completes the screen but the family wants the results to be considered by other relevant long-term support system, separate consent to share confidential information may be required.

Example: A family contacts the Family Support Program to apply for these supports and services. In the course of completing the screen, it appears that the child will also be COP and Waiver eligible. The screen information can be shared between members of the same agency on a need- to- know basis. However, if the lead agency for COP or the Waiver is different, a release of information will need to be obtained from the family before access to CLTS-FS information is granted to a different agency.

All information can be viewed at the state level on a need-to-know basis. As part of the initial consent process, parent(s) will be informed that information entered into the screen will be entered into a state level system. However, these results will only be viewed at an individual

level when there is a need-to-know. For example, the screen completed by a Family Support Program is entered into the statewide computer system. The eligibility results indicate that the child is likely to be eligible for the Katie Beckett Program. The Family Support Program could refer the family to their regional Katie Beckett Consultant or, with proper consent, could notify the regional Katie Beckett Consultant if the family has a desire to have a Katie Beckett eligibility determination made for their child.

1.9 Screening and Re-Screening Requirements

The Home and Community-Based Services Waiver, the Katie Beckett Program and the Family Support Program require an initial screen to establish eligibility prior to receiving services. An annual re-screen, or recertification, is required thereafter to ensure continued functional eligibility.

It is critical that whenever the condition of a child enrolled in a LTS program substantially changes, the CLTS-FS be updated and the eligibility logic re-run to determine if the change in condition impacts their level of care or program eligibility.

It is important that when re-screens are done, that the screener review the child's previously completed screens for information and historical perspective. The CLTS-FS can be done more often than yearly if someone requests it.

1.10 The Screening Process

The screening process requires face-to face contact with the child being screened. No screen should be completed without a meeting with the child and parent(s), even if the child is unable to communicate.

The Interview Process
The CLTS-FS was not designed as an interview tool; screeners are expected to use their professional skills to adjust their interview style to the families and the situation. The CLTS-FS sections can be completed in any order.

Ideally, the required face-to-face interview should take place in the family's home with the child present. This home based visit is required if the family is applying for the Katie Beckett Program. It may take more than one contact with the child and parents to complete the screen.

Screeners should use their professional interviewing skills to gather information in a way that is appropriate for a given child and family. The screener will need to ask questions in a variety of ways and use collateral informants as necessary. Collateral informants include other family members, Birth to Three or school staff, formal or informal caregivers, health care providers, and agencies serving the child. Once again, the screener must always have a face-to-face contact with the child, even if other informants are used.

1.11 Reliability of Screen and Screeners

As stated above, the CLTS-FS will be revised based on stakeholders' feedback over the next months and years. It is generally recognized that any objective rating of a child's functioning, cognition, behavior and symptoms can be difficult – even more so with children. The difficulty calls for extra vigilance to ensure the greatest possible accuracy in the CLTS-FS. This is why screeners must be certified and why DHFS and screen pilots must participate in ongoing quality assurance processes.

Screeners should adhere to the following guidelines:

- Read and follow screen definitions and instructions closely.
- Go slowly and carefully enough to be accurate, even with a child you know well.
- Always select the answer that most accurately describes the child's functioning. The eligibility logic is very complex and uses information gathered from all sections of the FS; Do not exaggerate any particular answers in an attempt to make a child eligible. Just select the most accurate answers.
- Refer all questions to State clinical staff. In this way, interpretations can be consistent and communicated to all programs utilizing the CLTS-FS, and when necessary, revisions can be made to the CLTS-FS.

1.12 Screening Limitations

Research shows that the following limitations occur in all functional assessments or screens:

A. Self-reports (from children or parents) can be inaccurate.
B. Different people will describe a child's abilities, needs, and problems very differently.
C. People often provide different information at different times and/or to different screeners.
D. Functional abilities and needs can vary over time or across settings (e.g., home or school), making it difficult to select an accurate answer.
E. Screen answers vary somewhat depending on whether the screener knows the child.
F. Screen answers vary somewhat depending on how well the screener and environment.
G. While objectivity is the ultimate goal, some subjectivity may remain in some questions.

1.13 Strategies to Minimize Screening Limitations

This section outlines guidelines to increase inter-rater reliability of the CLTS-FS despite the limitations listed above.

A. Apparently Inaccurate Reports
Functional eligibility screens cannot be merely applicant/family self-report; nor can they be merely screener's judgment. Both of these extremes allow for too much subjectivity. Instead, the goal is to be as objective as possible, to have **high "inter-rater reliability"--meaning that other screeners would choose the same answer you did.** For this to happen, you must gather as much information (objective data) as possible, and then ask, "Given all this information, what would other screeners choose for an answer?"

Asking questions, asking for demonstrations, and observing evidence carefully provides additional objective information. Be curious, not critical, about the reasons people say what they do. In addition to completing the CLTS-FS, you will often also be addressing applicants' emotions and needs that might be affecting their perspective. This is why screeners must be experienced in working with children and families.

If further questions and observations don't indicate the best answer for the CLTS-FS, consider any other information you see in health or school records.

In summary, screeners should follow this three-step process:

1. Ask more questions and rely on your observation. Ask for details, perhaps a demonstration. Consider the whole picture, to see if the "pieces" make sense.
2. As much as is part of your current practice, seek additional information from other people (other parent, teacher, therapists, MD, etc.).
3. Ask, "Given all this information, what would other screeners choose for an answer?"

If still not clear, refer the question to your Screen Lead, who will contact State clinical staff if necessary.

B. Different Descriptions from Different People

Different people will describe a child's abilities, needs, and problems very differently. This is expected due to varying perspectives among reporters, and because children often act differently in different settings or even with different people. Parents' perspectives and knowledge often are very different from that of a professional who sees the child only once a week. Children may in fact act very differently at school and at home. Adults' opinions, values, stresses, coping abilities and risk factors all affect how those adults describe a child's needs and behaviors. Cultural differences can also create differences in how people perceive and describe a child.

Again, consider additional information available to you, such as health or school records. Then ask, "Given all this information, what would other screeners choose for an answer?" If the differences are because a child's status differs, say, between school and home, then follow the instructions for "Abilities Fluctuate" below.

During a screening, parent(s) may convey a wide variety of emotions and attitudes. Your job is to recognize and respond to those feelings and perceptions and to help. In addition, your job is to get the most accurate description of the child's functional abilities. You need to be aware of how stress (and interpersonal and family dynamics) can affect perception of a child's behaviors and needs. It's NOT that professional opinions override parents; it's that you address parents' views and engage with interest and curiosity, with questions that gently focus on objective information about the child. Here again is the three-step process to follow:

1. Ask more questions and rely on your observation. Ask for details, perhaps a demonstration. Consider the whole picture, to see if the "pieces" make sense.
2. As much as is part of your current practice, seek additional information from other people (other parent, teacher, therapists, MD, etc.).
3. Ask, "Given all this information, what would other screeners choose for an answer?"

C. Abilities Fluctuate
Because it screens for **long-term** needs, the CLTS-FS is not a "snapshot" view of a child's current status. We realize that children's abilities, needs, and behaviors do vary. This can sometimes make it difficult to choose the most accurate answer on the CLTS-FS. In completing the screen, please follow this guideline:

- Responses to ADL/IADL questions should reflect the child's needs at least **a third of the time**. If the help is needed less than 30% of the time, do not check that help as needed. In general, consider ADL/IADL function over a six-month timeframe, unless the child has new needs or has developed new skills.
- Mental health and behavioral questions have different requirements described in the instructions for those sections.

There is a special question on the CLTS-FS to indicate that a child "**does not have impairments now, but has a verified diagnosis that is expected within one year to cause substantial functional impairments**." Such children may be eligible, even if they currently have few or no functional impairments. This is discussed in more detail in the ADL/IADL section.

Remember that the screen is taken in total; even if some ADLs are not checked, the child could be eligible through different sections of the CLTS-FS.

1.14 Impending Discharge

When screening a child who will be discharged within a week or so from a skilled health care facility (e.g., hospital, ICF-MR, State Center, IMD), complete the screen based on how the child would function when they go home. This looking ahead is a normal part of discharge planning. If, for example, oxygen and intravenous (IV) will be stopped before the child goes home in two days, do not mark them on the screen. If the family is learning to do a two-person pivot transfer to prepare to use at home, mark that on the screen, even if now the hospital does one-person transfers with a mechanical lift. It will take additional time and talking with facility staff, family, etc., to get the most accurate picture of the child's needs at home, after discharge.

The screener must be able to envision the child at home. This is why screeners must have experience in community care for the target group being screened. The CLTS-FS should be redone if the child's condition or situation changes from what was expected at the time the screen was completed.

MODULE #2: Informational Pages

2.1 Individual Information

Demographic information collected for the CLTS FS does not determine eligibility for LTC services. “Other” boxes are available in some instances to allow you, the screener, to fill in answers that may not be provided in the drop down boxes.

2.2 Referral Date and Screen Begin Date

The Referral Date may be used for a more limited purpose-namely, to assess state and local systems for timely responses to families’ requests for screening. In the adult Functional Screen, the difference between the Referral Date and the Screen Begin Date is tracked as part of quality improvements to ensure timely responses to requests for screening. We think a similar mechanism may be eventually useful in children’s programs. (Note: This is quality improvement for *systems*, not individual screeners. For instance, if one county always takes, on average, three weeks longer than other counties, there may be local systems changes they can make to improve their response time.)

For ***County Programs,*** the **Referral Date** is the date you received the initial request for service from a parent/guardian or another referral source.

The **Screen Begin Date** is the date of your first face-to-face contact with the child and parent.

If some additional information must be obtained, the **Screen Completion Date** (recorded on the last page of the CLTS-FS) will be later than the Screen Begin Date. There is an edit in the program that will generate an error message if the Referral Date entered is more than 60 days prior to the Screen Completion date. This is to cue screeners there may have been a typo error in the dates entered. It is only a cue and will not stop you from completing the Functional Screen and getting eligibility results.

For Katie Beckett Consultants Only

For *the **Katie Beckett Consultants only,*** the **Referral Date** is the date that a parent/guardian calls to schedule a home visit for eligibility determination. The CLTS-FS Referral Date is **not** used as the MA application date.

- Children’s home visits are often delayed by families’ need to reschedule and by other factors such as illness, snowstorms, etc. Many families never follow through after initial contact, while others may contact you months before they even move into Wisconsin. For these reasons, the definition and use of “Referral Date” needs further clarification, as follows: Use the date the family contacts you to **schedule** a home visit as the Referral Date (whether you talk to the family directly then or not).

  Example A: A parent leaves you a voice mail message on Monday 7/9/03 saying that they’ve gathered their documentation as you instructed and would like to set up a time for you to come

out to their house. On 7/11 you call the parent; due to her work schedule, the home visit cannot occur until 7/31. You would use 7/9/03 as their Referral Date.

Example B: A parent calls you in June because they are moving back to Wisconsin and want to apply for KBP. On July 20th, the parent calls again to say they have moved into Wisconsin and would like to schedule the home visit, to occur in the next few weeks. On the CLTS-FS, July 20th (not June) is the Referral Date; because that's the date the parent contacted you to actually schedule the home visit. If the family later requests the home visit be re-scheduled, you would then use this 2nd date for the Referral Date.

Example C: The same mom calls you on 7/28 to say that 7/31 won't work after all, as her work schedule was changed unexpectedly. You reschedule the visit to 8/8. Now the Referral Date is 7/28.

- If the consultant makes the home visit but it cannot be completed because, e.g., the family is not prepared or the child is not present, you would use the next "request date" (which may or may not be the date of the unsuccessful home visit) for the referral date.

  Example D: You go to a scheduled home visit on 8/15 and find that the parent and child are gone. The grandmother says they forgot all about your visit. You ask the mom to call you to reschedule. On 8/17 mom calls you to reschedule. 8/17 is now the Referral Date.

  Example E: You go to a scheduled home visit on 8/30. The mother is present, but the child is not; the mom seems to have forgotten that you need to meet the child. While you're still there, you reschedule another home visit. 8/30 is now your Referral Date.

  Note that in all of these cases, **the Referral Date is the date the family requests to schedule a home visit to complete the CLTS-FS.**

- If the home visit cannot be completed as scheduled due to circumstances beyond your control, e.g., your own illness, or a snowstorm, you would keep the parent's original request date as the Referral Date, even though the home visit must be rescheduled.

The **Screen Begin Date** is the date of your first face-to-face contact with the child and parent.

2.3 Screen Type

Select one option from the drop down box. There are three screen type options:

Screen type 01, Initial Screen—The first Long-Term Care Functional Screen completed for a person interested in understanding his or her long-term care status. Anyone may request a Functional Screen. Additionally, anyone can be referred for a Functional Screen.

Screen type 02, Annual Screen—An annual/recertification screen required as long as a consumer is enrolled in a home and community-based waiver program (KBP/Children's Waiver/FSP/COP/CIP/W). This type of screening is required annually.

Screen type 03, Change of Condition—At any time when a consumer's physical, emotional or living condition changes significantly they may request and/or receive additional screenings.

2.4 Referral Source

Select from the drop down box to indicate who (the applicant, a family member, friend, etc.) contacted the screening agency to refer this person for a Screen. If no referral was made (e.g., you are doing a recertification screen) select other and write in "recertification".

2.5 Child's Basic Information

Primary Contact
Check the Primary Contact box if the person is over 18 years old and is a competent adult (i.e., does not have a court-appointed guardian). If guardian of person proceedings are in process do not check this box. You can write a note about pending guardianship in the Notes field.

Name
If the child has a title such as "Jr." or "IV", list this in the Last Name box, following their last name.

Street Address/City/State/Zip/Phone Number
Enter the child's "permanent residence" address. For transient persons, enter the address they lived at the most in the last six months.

If there is a street address and a PO Box, enter street address and apartment information on line 1, PO Box on line 2, and use the PO Box ZIP Code.

The home telephone number is a required field. If the child has no telephone enter all "zeros" (000) 000-0000.

Date of Birth
Enter the child's date of birth in **MM/DD/YYYY**, as in 01/01/2002. The "/" must be entered between the field elements. CLTS-FS programming will not allow dates to be entered that make the applicant more than 22 years old. In this instance the person should be referred for an adult screen. The date of birth must be earlier than the screen begin date.

County/Tribe of Residence and County/Tribe of Responsibility
Select the appropriate county/tribe from the drop down box. In most cases these will be the same. In a few instances, persons may live in one county but another county/tribe is responsible for services, costs, and/or protective services. For the purposes of screening, residency is physical presence or the intent to reside. The CLTS-FS program will automatically enter ("default") county of responsibility to be the same as county of residence. This can be overridden if different counties are involved.

Are the child's parents aware of the legal concerns (e.g. Guardianship, Power of Attorney, and Representative Payee) once the child turns 18 years old?
This is a required field once the child is 16 years old. It is not necessary to know what the family is choosing to do when the child reaches 18, only whether or not they are considering the issues involved.

Is the applicant a competent adult?
If a child is listed as their own "Primary Contact" it is assumed that they are considered a competent adult. If the child is not requiring guardianship of the person, they are considered a competent adult.

2.6 U.S. Citizenship

This is a required field, as federal laws require U.S. citizenship verified for Medicaid eligibilities. Ask for the date of the child's entry into the United States either from family documentation and/or BCIS (Bureau of Citizenship and Immigration Services). Inform family the Immigration card MUST be viewed at the time of home visit and a copy must be included with the child's application materials (if applying to the Katie Beckett Program). If getting a copy would produce undue hardship for family, the screener should make note of that and indicate the card was viewed and verified. (Make sure it is the child's card and number that is recorded NOT that of a parent.) ALL new, legal entries into U.S. have or should have received an alien number upon entry. If a family says they don't have anything; they are probably undocumented. Non citizens who arrive in the United States ON or AFTER August 22, 1996 have a five-year BAR from Medicaid (Katie Beckett Program). Two exceptions are:

- U.S. veterans, active duty U.S. military, their spouses and dependents.
- Refugees, asylees, those granted withholding of deportation, for the first five years in the U.S.

Adoption from another country:
The Child's Citizenship Act of 2000 states that if all criteria for the adoption of a child born outside the U.S. are met and the parents have documentation of their foreign adoption through an official agency, the child **is** a naturalized U.S. citizen. The family should have some documentation from the child's country of origin that makes the baby/child legally declared an orphan and/or free to be adopted out of the home country.

2.7 Race/Ethnicity

RACE
This is not a required field. For persons with mixed heritage check all boxes that apply or check "Other" and write in the multiple races. The choices here match federal insurance reporting requirements. If needed, use the following definitions to identify the appropriate option:

- **Black or African American**: "Black" refers to people having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black," African American, Afro-American, Nigerian, or Haitian.

- **Asian or Pacific Islander**: Refers to people having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent. It includes people who indicate their race or races as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” or “Other Asian,” or as Burmese, Hmong, Pakistani, or Thai. “Pacific Islander” refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race or races as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” or “Other Pacific Islander,” or as Tahitian, Mariana Islander, or Chuukese.

- **White**: “White” refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “White” or as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

- **American Indian or Alaskan Native**: “American Indian and Alaska Native” refers to people having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicate their race or races as Rosebud Sioux, Chippewa, or Navajo.

ETHNICITY
This is not a required field. If needed, use the following definition to identify the appropriate option:

- **Spanish / Hispanic / Latino**: A person of Mexican, Puerto Rican, Cuban, Central, South American, or other Spanish culture or origin, regardless of race.

2.8 Interpreter Language Required

Leave this blank if no interpreter is needed. Select the appropriate language if an interpreter is needed. If “Other,” please type in the language needed. Human service and health care providers should always obtain interpreters when they are needed. This information will help show the extent of such needs, and will also help long-term care programs better serve non-English speaking consumers.

2.9 Contact Information

Additional Contacts
For children under age 18, at least one Additional Contact must be entered. For applicants 18 or over, if “Primary Contact” is not checked for the applicant, then at least one Additional Contact must be entered.

DHFS correspondence will be sent to the first Primary Contact listed.

A second Primary Contact (e.g., a second parent) can be listed if s/he has legal responsibility for the child. If they do not have legal responsibility, they can still be listed as “additional contacts” but not as a “Primary Contact.” A warning box will appear on the Functional Screen reminding

the screener to be certain that multiple "Primary Contacts" have legal rights to the child's records.

In cases of joint custody in which one parent does not reside with the child, that parent's contact information should be included. If the second parent does not have joint custody, this information is optional.

For convenience, the child's address and home telephone number will auto-fill in Additional Contacts 1 and 2. You can delete or write over this information if it is not correct for the contacts. If a contact person's name is not clearly gendered, you can note the person's gender in the Notes section for others' future reference.

If there is a street address and a PO Box, enter street address and apartment information on line 1, PO Box on line 2, and use the PO Box ZIP Code.

The home telephone number is a required field. If the person has no telephone enter all "zeros" (000) 000-0000.

If a contact person does not have a known address, put the person's name and any additional information you have in the note section on this page.

2.10 Child's Medical Insurance

Check all that apply. BadgerCare, General Assistance Medical (GAM) and MAPP are forms of Medicaid. If the child is on BadgerCare, General Assistance Medical (GAM) or MAPP, enter this information under Medicaid with the number, and put a comment about this information in the Notes section.

"Private insurance" includes employer-sponsored insurances (e.g., an HMO) available as a job benefit. Company name and policy number can be filled in if available, or left blank if not.

2.11 Primary Care Provider and Type

This is a required field. The information does not affect eligibility. It may eventually be used for state and local systems changes to improve children's access to primary health care.

2.12 Living Situation

Where Child Currently Lives
Check one box. If you select "other," type an explanation in the "other" box. Most of the drop down box menu options are self-explanatory. For further clarification:

"CBRF" includes "group home."
Other IMD = Other Institute for Mental Disease.
Residential Care Apartment Complex (RCAC) is what is commonly (or formally) known as "assisted living."

Prefers to Live (if age 18 or over)
Check one box. If you select “other,” type an explanation in the “other” box.

For applicants age 18 or over, this question asks precisely and only for the consumer's own stated preference. It will be used to see if long-term care consumers are living where they want to live and to track changes over time. This question is asking the **person's informed preference. Record where s/he would like to live - not where anyone else wants them to live, and not where you or others think is realistic.** Screeners must take the time to explain the person's options. The person cannot express a preference if the screener has not informed them of their options first.

It is well known that people often acquiesce to whatever they feel limited to or whatever they've been told. For example, people with developmental disabilities who live in institutions often think “group home” is the only option available to them. You must take the time to ask questions to help the person articulate her/his preferences. Some people like to live with others; others highly value having their own space. While the person's preference may be difficult to ascertain, screeners are to use their best interviewing skills to select the most accurate answer.

Screeners should select the answer that most accurately reflects what the person is saying. If a person with developmental disability is telling you that she wants “a place of my own,” then you select the most appropriate selection of “own home or apartment.” Do NOT select “someone else's home or apartment” or an “apartment with services” even if that is probably what the person would get. The purpose of this question is to record what the person says, not what the system will provide or what you think s/he really needs.

If the applicant's preferred living situation is not listed, select “Other” and please type in what the “Other” is, for possible screen revisions in future.

Guardian/Family's Preference of Living Arrangement for this Person
This question is only for people age 18 or over, and accompanies the previous question about the consumer’s preference on where to live. It was added because screeners found completing the “Prefers to Live” too difficult to answer accurately when the guardian or family disagreed with the consumer’s preference. It has no bearing on eligibility. Select the most appropriate option from the drop down box menu.

If the child is not currently living at home, is there a plan to return to home within six months of screening date?
This question affects eligibility for some home-and community-based programs as well as the Family Support Program. The question is related to a specific plan to return the child to the home rather than a permanency plan.

MODULE #3: Diagnoses

3.1 Has the child been determined disabled by the Disability Determination Bureau (DDB) or by a Social Security Administration?

Check “Yes” if, within the past 12 months, the child was in the Katie Beckett Program or on Social Security for a disability, in any state. This can be checked “yes” based on parent report.

3.2 Transplanted Organ

If child has had a transplant, indicate the date completed. If pending one, check the appropriate box. Some children have had a transplant and are pending another one of the same kind or a different kind. The Functional Screen will allow for both possibilities. List all pending as well as previous transplants. If you complete a screen for a child pending a transplant and you sensed that the child would meet eligibility requirements for a certain program but they did not meet eligibility requirements, call state staff to discuss the outcome of the screen.

3.3 Pending Diagnoses

In many instances, physicians cannot diagnose a baby until s/he gets older. In those cases, other Functional Screen questions can determine correct program eligibilities for the baby, and diagnoses do not matter.

3.4 Diagnoses Cue Sheet

The diagnoses table is not all-inclusive; only some of the more common diagnoses are here. Also, many different diagnoses mean the same thing. For brevity, this table includes the most common and the most “important” diagnoses you will encounter. “Important” diagnoses for the Functional Screen means those that are specifically mentioned in state or federal eligibility requirements. In other words, some of the diagnoses on the table are required for a child to be eligible. That’s why accurate diagnoses are very important for the Functional Screen.

You will sometimes encounter diagnoses that you do not see listed in the table. **Most** of the time these will be synonyms for listed diagnoses. If you don’t see a particular diagnosis listed on the table itself, look for it on the Diagnoses Cue Sheet. The Cue Sheet will tell you which box to check on the Functional Screen Diagnosis Table. If the diagnosis is not on the cue sheet, then you can check the “Other” box and write it in. (Screeners’ entries will be reviewed periodically to update the Cue Sheet.)

3.5 Diagnoses and Eligibility

Reliable diagnoses are difficult to obtain even from health care professionals; obtaining accurate diagnoses is even more challenging for screeners doing home visits. Given these limitations, whenever possible we avoid having diagnoses affect eligibility determinations in the CLTS-FS.

3.6 Completing the Diagnoses Table

Screeners are not to interpret people's complaints or symptoms. If parents report a diagnosis to you: Ask the parent, "Can you tell me more about that? Was that diagnosed by a doctor? When was that diagnosis made?"

- If parent can report that an MD or psychologist diagnosed the child, you can check the diagnosis box.
- The point is to try to separate the parent's opinion or suspicion (which shouldn't be checked for diagnoses) from parent's report of diagnoses that were made by doctors or qualified psychologists.
- School records and Birth-to-3 records do not count for diagnoses unless the records state that the diagnoses were made by properly qualified professionals e.g., MD or psychologist. The exception to this is that Birth-to-3 professionals are qualified to make the diagnosis of "Developmental Delay" only.
- If a teacher, social worker or therapist has told the parent of a diagnosis, that does not count for diagnoses. Even if school personnel have done an Autism rating scale, do not check the diagnosis of Autism.
- Only check the diagnoses that have been reported to you or that you see in appropriate documentation. Do not interpret diagnoses from symptoms. For example, if a child has multiple delays in a variety of areas (learning, mobility, self care) do not assume they have a diagnosis of Developmental Delays or Developmental Disabilities. Only check the diagnoses that you have verbal report or written record of.

If you suspect that a parent is over stating a child's disability, you will want to confirm the diagnosis with a qualified professional.

Diagnoses Listed in Table
If you see the child's particular diagnosis listed in the diagnosis table, check it. You do not then need to check all the synonyms for that diagnosis.

Example: Child has "Down syndrome," you check that box. You do not have to also check synonyms such as "mental retardation," "developmental disability," and "genetic/chromosomal abnormality."

Multiple Conditions/ Diagnoses
A child may have more than one condition - e.g., Cerebral Palsy and cancer. In those instances, both Cerebral Palsy and cancer would be checked. The Functional Screen should "paint a picture" of the child that makes sense.

Example: You screen a child with Muscular Dystrophy and you also check (in the health-related services table on page 9 of the Functional Screen) that the child is getting IV's. A second

diagnosis should be present to explain (to a knowledgeable reviewer) why the child is getting IVs.

Check all diagnoses that apply to a child! Sometimes a child may have a primary diagnosis as well as secondary diagnoses, again, check all diagnoses. If you think the primary diagnosis captures the functional limitations that the child has, it is still important to list all diagnoses a child has.

Example: You meet a boy who has a diagnosis of Cognitive Disability and also has Asthma and Allergies. The functional limitations he experiences are directly related to his diagnosis of Cognitive Disability. Nevertheless, you would check all three diagnoses on the Diagnoses Page.

Diagnoses That Apply
Most of the diagnoses you encounter are essentially permanent conditions, such as Down syndrome, Genetic/Chromosomal disorders, Cerebral Palsy, Spina Bifida, etc. Those conditions may have been diagnosed years ago, and are still applicable for the child. You would check them on the Functional Screen.

There are a **few** diagnoses on the table that are conditions that can go away. Cancer, a wound or burn, failure to thrive, even some mental health diagnoses, are examples of conditions that might not really **apply** to a child any more. If a condition has gone away so much that the child is not on any medications or treatments for it and no longer has any symptoms from it, then that diagnosis should not be checked on the Functional Screen table.

Example A: Ricky is a 15-year-old boy with Muscular Dystrophy. When he was 6 he was successfully treated for Leukemia. He's had no recurrence or symptoms related to Leukemia since then. Screener would not check Leukemia on diagnosis table.

Example B: Sophia is a 5-year-old girl who's doing well and is typical size, weight, and development for her age. As an infant she was diagnosed with Failure to Thrive, but that was resolved by the time she was 3. Screener would not check Failure to Thrive on diagnosis table.

Screeners are not expected to make clinical decisions about whether or not a previous condition still affects a child. When you are not sure, go ahead and check the diagnosis in the table.

MODULE #4: Mental Health

4.1 Diagnosed Emotional Disability

"If the child has a clinical diagnosis of an emotional disability, has the diagnosis, or symptoms related to that diagnosis, persisted for at least six months?"

- ☐ **Yes**
- ☐ **No**
- ☐ **Child does not have an emotional disability**

"If the child has a clinical diagnosis of an emotional disability, is the disability expected to last a year or longer?"

- ☐ **Yes**
- ☐ **No**
- ☐ **Don't know**
- ☐ **Child does not have an emotional disability**

These questions reflects current duration requirements for a Psychiatric Level of Care (LOC). Note that the **Autism Spectrum Disorders are Mental Health diagnoses**; you may check this box for children with those diagnoses. (These include Asperger's, Autism or Autism Spectrum Disorder and Pervasive Developmental Disability.)

Regardless of the answer to this question, complete the Mental Health section for every child who has a mental health diagnoses.

4.2 Mental Health Symptoms/Minimum Frequency

The minimal frequency of mental health and behavioral symptoms is lower than the "needs help one-third of the time" criterion used for ADLs and IADLs. For the mental health symptoms, you should check the box if:

- Child currently has symptoms as defined, or
- Child had the symptoms as defined within the past three months, or
- Child had the symptoms as defined at least twice in the past year.

Does child have any of the following symptoms? (Check all that apply.)

- ☐ Psychosis - Serious mental illness with delusions, hallucinations, and/or lost contact with reality.
- ☐ Suicidality - Suicide attempt in past three months or significant suicidal ideation or plan in past month.
- ☐ Violence - Life-threatening acts.
- ☐ Anorexia/ Bulemia - Life-threatening syptomology.

For Psychosis and Anorexia or Bulimia, there should be a corresponding diagnosis in the Diagnosis table of the Functional Screen.

Violence is defined as life threatening acts that endanger another person's life. This includes life-threatening acts that result in one of the following:

- Cause other person to require hospitalization (does not include an ER visit).
- Use of weapons against someone (e.g., gun, knife, chains, switch blade).
- Arson (purposeful fire setting) or bomb threats.

If the behavior does not meet this requirement, you may be able to check Aggressive or Offensive Behavior on the Behavior Page of the CLTS FS.

Anorexia/Bulemia - Life threatening syptomology. Effects of eating disorders must include at least one of the following:

- Malnutrition (Diagnosed by MD).
- Electrolyte imbalances (diagnosed by MD). Electrolytes are body salts like sodium, potassium and chloride.
- Body weight or development below 20th percentile due to the eating disorder (as determined by physician).

4.3 Mental Health Services

Does child currently *require* services from any of the following? (Check all that apply.)

- **Mental Health Services:** Psychotherapy specific to the child's diagnosis, including day treatment programs (except substance abuse only, which is captured below.) This also includes **in-home therapies for children with Autism or Autism Spectrum Disorders.**
- **Child Protective Services**
- **Criminal Justice System (includes Juvenile and Adult Justice Systems)**
- **In-school Supports *for Emotional and/or Behavioral Problems***
  "In-school supports" includes special education classes, one-on-one assistance, or a behavioral plan in an Individualized Educational Plan (IEP). This is for emotional or behavioral problems; do not check it for children with only cognitive and/or physical disabilities.

  Sometimes children have behavioral plans that are essentially inactive because the child has not had the behavioral problems for a long time. If the child is not in special education classes and does not have one-on-one assistance, check this item only if the behavioral plan has actually been used. In this situation, check the box if interventions are needed **at least three times per week**. **"Interventions"** here means a school staff must verbally and/or physically provide or assist the child with behavioral controls. The staff person may have to interrupt or prevent the behavior, remove the child from the situation, or respond in ways to help the child cope and avoid harm.

- **Substance Abuse Services:** Includes day treatment and outpatient services.

Most children who "require" these services should be receiving them. Check these items even if the child or parent cannot or will not participate in recommended services or if the recommended services are not available. "Required" is not just the screeners' opinion, however; the services should be recommended by a qualified professional.

MODULE #5: Behaviors

5.1 Overview of Behaviors

This section serves two purposes:
1. To allow screener to describe behavioral symptoms in any child, and
2. To present existing criteria for eligibility for Psychiatric and DD levels of care.

"Behaviors" is a completely separate section from "Mental Health" on the Functional Screen. You may check behavioral boxes for children who do not have emotional disability or mental health symptoms. In other words, the Behavioral section allows you to describe behavioral problems that result from cognitive, emotional or social impairments.

5.2 Is child currently an adjudicated delinquent?

This question reflects long-standing policy to avoid cost shifting from the Department of Justice to the Family Support Program. If a child is an adjudicated delinquent, then the justice system is responsible for providing whatever assistance the child and family needs, and the child is not eligible for FSP. This includes youth being tried as adults.

"Adjudicated delinquent" means that a child—currently or within the past year—is or has been under supervision of the juvenile justice system because they violated the law, misbehaved, or posed a threat to others due to their conduct (Chapter 938 of Wisconsin State Statute). This does **not** include court orders for treatment, or a CHIPS petition (Chapter 48 of Wisconsin State Statute), i.e., a child needing protective services.

5.3 Specific Behaviors

The behaviors listed are precisely defined to increase inter-rater reliability. Please follow the definitions precisely and contact designated State staff with questions.

Behaviors – Minimum Frequency
The minimal frequency for behavioral symptoms is lower than the "needs help 30% of the time" criterion used for ADLs/IADLs. For **behaviors** you should check the box if:

- Child currently has the behavior as defined, or
- Child had the behavior as defined within the past three months, or
- Child had the behavior as defined at least twice in the past year.

Do not check multiple boxes for one behavior
While from one perspective the definitions of behaviors overlap somewhat, from another perspective, each listed behavior looks for a specific problem not captured in the other behaviors or as a symptom on the Mental Health page. This makes the Behaviors section as **inclusive** as

possible, but requires that screeners follow definitions precisely and do not check multiple boxes for single behaviors.[2]

For example, if a child eats inedible objects (this is called "pica") you would check self-injurious behaviors, which includes pica. You would not also check "lack of behavioral controls" or "high-risk behaviors" for pica. Similarly, if a child is suicidal, you would check suicidality in the Mental Health section above, but would not also check "lack of behavioral controls" or "high-risk behaviors" or "self injurious" in the Behaviors section.

Of course if a child has several of the listed behaviors you check each behavior that applies. For example, if a child has aggressive or offensive behaviors and also has an unrelated self injurious behavior, you check both. Likewise, if a child is suicidal and also engages in unsafe sexual behaviors (High-Risk Behavior), you check both.

"Social Skills" and "School and/or Work" allow overlap
The "Social Skills" and "School and/or Work" items can be checked regardless of the other behaviors listed. For example, some children with aggressive or offensive behaviors demonstrate typical social skills, so these are separate items. The "Social Skills" boxes should be checked only if the child has the specific behaviors listed for their age group.

If the same behavior that lead you to check any of the listed behaviors on the Functional Screen have also contributed to the child's need for special educational support at school (or work), then it is permissible to check the "School and/or Work" item as well.

Check the boxes that describe the child's behaviors, even if adults are keeping the child safe, and even if adults are preventing the unsafe behavior. Ask, "Would the child do these behaviors if the supports were removed, or if they were not in this special environment?" If yes, then check those behaviors to describe the child's condition. "Supports" here does not include medications.

5.4 Definitions of Behaviors

<u>High-Risk Behaviors</u>: Consistent lack of age-appropriate decision-making or judgment.
May include risky behaviors such as unsafe social or sexual behaviors, substance abuse, running away, running into traffic:

- ☐ Child is unable to understand risks.
- ☐ Child is cognitively able to understand but still engages in high-risk behaviors.

This question looks for "consistent lack of **age-appropriate** decision-making, judgment and value systems." It is intended to describe the child who needs extreme precautions in place and/or the child who cannot be trained or re-directed as expected for their age. See examples below.

[2] This is not for eligibility so much as for making sense of FS data, both individually and in aggregate data. Having multiple behaviors checked for just one behavioral problem would make the data less meaningful.

This question does not include suicide attempts, which should be checked in the Mental Health section above.

Since safety and values are rather subjective, it is important to follow the definition precisely. The behaviors listed are quite "extreme." That is necessary to limit this to children eligible for long-term support programs, as opposed to typical risk taking behavior in children and teens.

"Substance abuse" means risky use of alcohol or other drugs. Since the majority of teens try alcohol, cigarettes, and/or marijuana, for eligibility purposes limit "substance abuse" to the child who is in need of or receiving addiction treatment.

The two options under "High-Risk Behaviors" allow you to describe two very different sorts of children with this one question:

"Child is unable to understand risks": Since the definition specifically omits **age-appropriate** high risk behaviors, you would check this box only for a child with significant cognitive impairments. Check this box even if others keep the child safe.

Example A: 5-year-old child with Autism who frequently bolts through any open door or out of cars and runs into traffic. While a 5-year-old can't cross heavy traffic alone, 5-year olds know not to exit a moving car or run out into traffic (hence these specific behaviors are not "age-appropriate"). This child does not understand the risk. Screener checks this box for this child.

*Example B: 16-year-old girl with significant cognitive disability, who is unable to recognize or respond to risks. She is safe and well cared for, due to 24-hour care by her family. Without someone there, she would wander off and approach strangers. She is not safe alone at home or in public, and she **would engage** in high-risk behaviors without others' interventions. You do check this box for her.*

*Example C: 16-year-old girl with significant cognitive disability, who is unable to recognize or respond to risks. She also has severe physical limitations and cannot transfer or move her wheelchair. She is not safe alone at home or in public, but she **cannot engage** in any risky behaviors due to her severe physical limitations. You do not check this box for her.*

"Child is cognitively able to understand but still engages in high-risk behaviors."
This box lets you describe older children with high-risk behaviors.

Example: Jessie is a 13 year old who often stays out all night, drinks heavily and uses various street drugs, and engages in frequent unprotected sex with strangers for money or drugs. Screener checks this box for her.

As you encounter other examples of behaviors **not** listed here, please report them to State staff, so this question can be as objective and precise as possible.

Self-Injurious Behaviors: Head-banging, self-mutilation, polydipsia, pica
This question **is restricted to the four specific behaviors listed** that require immediate intervention to prevent severe injury or death. Less damaging, repetitive or stereotyped behaviors

are not included. This question also does not include other behaviors that can be interpreted as self-injurious, such as overeating, promiscuity, or smoking.

- "Head-banging" means banging one's head against hard surfaces or beating it hard with the hands, but not just tapping one's head repeatedly.
- "Self-mutilation" means cutting or burning oneself, biting oneself severely, tearing out one's eyes or teeth, inserting harmful objects into body orifices, etc. It does not include tattoos, piercing, nail biting, pulling hair, or skin picking. Self-cutting or burning is less severe and not life threatening, but it is included here for eligibility purposes because the child may need help with mental health issues.
- "Polydipsia" refers to a life-threatening behavior, seen only in a few children with severe mental illness or cognitive disability, in which the child drinks excessive amounts of water. Others must intervene to prevent illness and death.
- "Pica" means that the child eats inedible objects that could be life-threatening (not merely unusual). Examples include: swallowing metal objects like keys, bolts, etc. Examples do not include: swallowing paper, dirt, paste, etc.

Aggressive or Offensive Behavior Toward Others: Includes behaviors such as hitting, biting, kicking, spitting, or masturbating or disrobing in public. Also includes sexually inappropriate behavior towards children or adults.

Aggressive behaviors include hitting, biting, or kicking. It also includes serious threats of violence. Aggressive behavior also includes abuse and torture of animals. This does not include rough-housing or an average level of fighting among siblings. Offensive behaviors include spitting, or masturbating or disrobing in public.

This question is intended for various sorts of **atypical** behaviors that require special interventions.

Do **not** freely interpret "offensive." It is restricted to spitting, or masturbating or disrobing in public. Other behaviors can be indicated in "lack of behavioral controls" (discussed below). And since this question is looking for **atypical** behaviors for long-term support program eligibilities, it does not include behaviors that are fairly common among children and teens, such as swearing, talking back or yelling at parents, etc. Please report any other behaviors you think should be added to the category of "aggressive or offensive behaviors" to State staff.

Check this box if the behavior indicates a **need** for intervention, whether the child is getting interventions or not.

Example: An 11-year-old boy has had several instances of sexual behavior with younger children in the past four months. His mother is overwhelmed and has not accessed any services for the child and has done nothing to intervene. Screener checks this box to indicate the behavior, despite the absence of interventions.

Lack of Behavioral Controls: Lacks appropriate behavioral controls such that child can not be at home or in community settings without causing disruptions or distress to others.

- ☐ Requires interventions weekly on average, or less often
- ☐ Requires interventions more than once within a week.

This is intended for children who do not meet the definitions for "high-risk," "self-injurious," "aggressive or offensive" behaviors but still have a lack of behavioral controls.

Example: 7-year-old child with Autism who screams and cries when he is taken anywhere.

If you already checked "high-risk," "self-injurious," or "aggressive or offensive" behaviors to describe the child's behavior, do not check "lack of behavioral controls."

This is a more general question intended to allow screeners to describe children who lack controls due to cognitive and/or emotional disabilities. It is difficult to reduce subjectivity in a general question like this. Note that it is **"age-appropriate"** controls; you would never check this for a baby. This item is looking for *unusual, atypical* lack of control.

"Interventions" here means an adult must verbally and/or physically provide or assist the child with behavioral controls. The adult may have to interrupt or prevent the behavior, remove the child from the situation, or respond in ways to help the child cope and avoid harm.

The frequency of interventions needed can vary, and it may take a few moments for the parent and you (and other contacts as necessary) to choose the most accurate answer.

Social Skills (Check all that apply):

For ages 7 months and up:

- **Does not make eye contact – Check the box if:**
  - The child does not have appropriate eye contact with familiar or unfamiliar people.

- **Does not make eye contact – Do NOT check box if:**
  - The child is blind or visually impaired.
  - The child uses only fleeting eye contact as if they were scanning the room and passed by your line of sight.
  - The child stares at people, as if looking right through them.

For ages 3 and up:

- **Absence or dramatic reduction of social interactions – Check the box if:**
  - The child used to play with peers and no longer has interest in friendships.
  - The child's social skills have not developed in an age appropriate fashion. They haven't lost any skills but they have not continued to develop social skills as they have gotten older.
  - The child has severe depression or other mental health issues. They used to have many friends but no longer interacts with them and has become isolated.
  - The child who does not spontaneously seek to share enjoyment, interests or achievements with others.

For ages 7 and up:

- **Unable to interpret others' non-verbal cues (e.g. body language, facial expressions) – Check the box if:**
  - The child cannot understand another person's mood without being told verbally.

- **Does not have similar aged friends – Check the box if:**
  - The child has friends but they are all much younger or older than the child.

For ages 14 and up:

- **Excessive familiarity with strangers – Check the box if:**
  - Child is at risk of abuse due to willingness to go off with anyone who entices him/her.
  - Child hugs people who they are meeting for the first time.

School and/or Work:

- ☐ Failing grades, repeated truancy and/or expulsion; suspension; and/or inability to conform to school or work schedule more than 50% of the time.
- ☐ Child needs in-school supports for emotional and/or behavioral problems.

Note that "Child needs in-school supports for emotional and/or behavioral problems" is the same as one of the services listed on the Mental Health page. It is appropriate to check this item in both places if it is applicable.

MODULE #6: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

6.1 Overview of ADLs/IADLs

The computer application of the CLTS-FS will calculate the child's age and present only the ADL/IADL answer choices appropriate for the child's age. If you are filling out the paper version of the CLTS-FS, you will need to take along a print-out of the ADL/IADL answer choices that match the child's age, and check the boxes. (You can print it from the "Forms" link in the CLTS-FS application.)

These answer choices were developed by the screen workgroup using well-established child development guidelines. Modifications were made in order to meet our screen development goals:

- Accuracy (match current eligibility rules and clinical judgment)
- Brevity (unnecessary information was left out)
- Objectivity/ inter-rater reliability (i.e., reduce subjectivity as much as possible)
- Inclusiveness (able to describe various needs of children)

These four criteria can obviously conflict. The balancing act is especially evident in the ADLs. The wording of each answer choice was crafted to be as precise and objective as possible to promote **inter-rater reliability**. This can obviously be challenging when trying to be **inclusive** of all children with or without physical, cognitive, or emotional disabilities.

Similarly, **brevity** can conflict with inclusiveness and accuracy, since children's abilities must be broken down by age groupings. If eligibility is not affected, brevity is chosen over inclusiveness. Since **age-appropriate** needs are not "necessary" information (they don't help with determining program eligibilities) they are not included among the ADL/IADL answer choices. This means that screeners **will not be able to describe every child's needs**, if the needs are "age-appropriate," i.e., similar to those of non-disabled children of the same age group. ("Similar" here means the same as, or **too difficult to distinguish** without subjectivity and excessive length of the CLTS-FS)

Age-appropriate descriptions (such as complete cares for infants) were left off the CLTS-FS for brevity. Phase one testing indicates children and babies are properly eligible even without checkmarks on some of the ADLs/IADLs.

6.2 Describing "Help"

"Help" means assistance from another person. It includes hands-on assistance, doing the task completely, verbal cueing, or close supervision throughout the task. In this way, help needed due to physical, cognitive or emotional disabilities or mental illness can be indicated.

6.3 Adaptive Equipment

Some items specifically ask whether the child needs adaptive equipment. Adaptive equipment includes "medical" equipment such as wheelchairs or mechanical lifts; it can also include "low-tech" equipment the parents use, such as strollers for a three year old who can't walk, or a baby seat to bathe a baby who can't sit on her own. Such low-tech or generic equipment count **only if** they are used to compensate for a child's **physical impairment**. (See details under "Bathing" and "Mobility.")

Note the term is "needs" equipment, whether or not the child currently has the equipment. Since screeners are not expected to assess for adaptive equipment needs, you will check this box when the child already has the adaptive equipment, or you will check other boxes to indicate the level of help they need from another person now, without such equipment.

6.4 ADL/IADL One-Third Rule

ADLs and IADLs are to be checked if the child needs help at least one third of the time.
In many cases, a child's need for help is fairly consistent: "She can't do that," or "He always does this," or "Most of the time…"

In other cases, the child's needs arise only some of the time. Very infrequent needs cannot count toward eligibility for long-term support programs.

When frequency is at question, screeners should use a simple **one third rule**: If the child has a limitation **one third** of the time (or more often) then it counts as a checked box on the CLTSFS. If the child has a limitation less than one third of the time, the ADL/IADL answer choice should not be checked.

The "one third of the time" criterion does not mean that the screener tests the child or measures her needs or abilities only on during the visit. If a parent says, "now and then," "every few weeks," or "a few times, not mostly," it's probably less than one third of the time. You can ask the parent "In the past few months, would you say he's needed help more than one third of the time?" In general, consider ADL/IADL function over a six-month timeframe, unless the child has **new needs** or has developed **new skills**.

*Example A: Juan has cancer and gets very sick during chemotherapy and he needs help with his ADLs then; at other times he is independent with them. Juan gets chemotherapy one week each month. Screener does **not** indicate that Juan needs help with his ADLs because he needs help less than one third of the time – one week out of four.*
*Example B: Tia was potty-trained two months ago and is doing well with it. Screener does **not** check box for needs help with toileting (although she did, four out of the past six months), because Tia has developed this skill and now rarely needs any help.*
Example C: Isabel is a 13- year-old girl with serious mental illness. Her need for help varies widely as she cycles from depression to manic states. Overall, Isabel needs verbal cueing or supervision (sometimes even hands-on help) more than one third of the time.

Remember that “help” includes supervision, verbal cueing, and partial or complete hands-on cares.

6.5 "Needs” versus “Safety”/ Fluctuating Needs

"Needs" and "safety" should not be over-interpreted or over-used to express screeners’ subjective opinions. The CLTS-FS is intended to be an objective screen of children’s need for assistance. Thus, you should ask yourself, "Would another screener of another discipline rank the child the same way?"

It is often difficult to distinguish a child’s needs from parents’ preferences. Sometimes parents may prefer to perform or help with tasks even though the child could do them. If a child can complete a task independently, but it takes them a long time, you need to consider whether or not the child "needs any help to complete the task." Sometimes it takes a child so long that the parent must do the task so that the child gets to school on time. This is not just for convenience, and amounts to (on average) more than a third of the time (since it’s five days out of seven); it would be counted as help needed on the Functional Screen.

You will quite often encounter different versions of the child’s abilities from different parties. This is discussed in the first part of the instructions. Also, there are instructions for how to deal with fluctuating needs, and with the fact that a child may function differently, e.g., at home and at school. Please review those earlier sections as needed under 1.13 Strategies to Minimize Screening Limitations (B. Different Descriptions from Different People and C. Abilities Fluctuate).

6.6 Age Specific ADL/IADL Answer Choices

The following tables provide information and guidance about the ADL/IADL questions on the CLTS-FS. The table is organized by ADL/IADL (Bathing, Dressing, etc.). The columns to the left side of the table indicate the age at which the specific answer choice appears on the CLTS-FS. The answer choices are listed in **Bold**. Following the specific answer choice is an explanation of the question and/or relevant examples. Always consider the answer choice itself first; the examples are only intended to supplement that. In the following tables, the symbol ☑ is used to indicate that if the information listed here is true for the child, you would check that box on the CLTS-FS. The symbol ⃠ is used to indicate that if the information listed here is true for the child, you would **not** check that box on the CLTS-FS. This is not an inclusive or exclusive list of information. The children for whom a CLTS-FS is completed for are complicated individuals, and every situation has not been represented on the screen or in these instructions. The information provided is meant to offer guidance to the screener. For most of the questions, the answers should be relatively clear once you have met the child and reviewed the available documentation. For further clarification, e.g. means “for example” and i.e. means “that is, or “in other words.”

6.7 Bathing

The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene (including shampoo). For older children, this also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash and dry fully.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
•											**Not applicable for the purposes of this screen.** This option does not appear on the functional screen because young children are expected to require assistance in this category.
	•	•	•	•	•	•	•	•	•	•	**Needs adaptive equipment.** ☑ Uses shower chair, tub bench, mechanical lift, or any other devices if they are used to compensate for the child's physical impairment. ☑ The parents/caregivers prefer another method and have not obtained adaptive equipment. ☑ The child is a year or older and unable to maintain a sitting position unsupported.
		•	•	•							**Becomes agitated requiring alternative bathing methods.** ☑ Becomes unsafe in bathing and needs to be constrained or sponge bathed. ⃠ Takes a shower rather than a bath.
					•	•	•	•	•	•	**Is combative during bathing (e.g., flails, takes two caregivers to accomplish task).** ☑ Extreme avoidance behaviors that make bathing unsafe for child and/or caregiver. ☑ Caregiver is in tub with child because of child's unsafe behavior.
							•	•	•	•	**Needs complete physical assistance.** It is expected that children under 5 years old may require some physical assistance, which is why this option is not available to those children. ☑ Requires someone to bathe them (hands on) whether in a bath or shower.
						•	•				**Needs to be lifted in and out of bathtub or shower.** ⃠ Able to get in and out, but parent chooses to lift them. ⃠ Needs hands on assistance, verbal cues or supervision but can get in and out without others lifting them.
								•	•	•	**Needs help in and out of bathtub or shower.** ☑ Needs hands-on assistance, someone to do the task completely, verbal cues or close supervision throughout the task.

BATHING

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
							•	•	•	•	**Needs step-by-step cueing to complete.** ☑ Needs someone with them throughout the bath/shower telling them each step of the process. ⃠ Needs reminder to bathe (e.g., "Don't forget to take a bath tonight"). ⃠ Needs reminders before the bath takes place (e.g., "remember to wash your hair"). ⃠ Needs an occasional cue, but not step-by-step instructions.
							•	•	•	•	**Lacks an understanding of risk and must be supervised for safety.** ☑ It is understood that if you checked "Is combative during bathing" then this would be also checked.

BATHING

6.8 Grooming

Brushing teeth, washing hands and face. Due to variations in hair care by culture, length of hair, etc, hair care is not considered for the purposes of this screen.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
•	•	•	•	•							**Not applicable for the purposes of this screen.** This option does not appear on the functional screen because young children are expected to require assistance in this category.
					•	•	•	•	•	•	**Is combative during grooming tasks (e.g., flails, clamps mouth shut, takes two caregivers to accomplish task).** ☑ Exhibits avoidance behavior that is extreme and requires atypical intervention. ☑ Needs one caregiver to hold them while another completes the task. ⃠ Runs around the house to avoid grooming tasks. ⃠ Doesn't like grooming tasks and fusses a bit, but not more than some peers.
						•					**Unable to wash hands.** ☑ Unable to turn on the faucet, apply soap, and rinse hands under the water. ⃠ Unable to select an appropriate water temperature.
							•				**Unable to wash hands or face.** ☑ Unable to turn on the faucet, apply soap, and rinse hands under the water. ☑ Unable to wash face using a wash cloth. ⃠ Unable to select an appropriate water temperature.
							•	•	•	•	**Needs physical help with grooming.** ☑ Needs parent/caregiver to brush teeth. ☑ Needs parent/caregiver to wash hands. ☑ Needs parent/caregiver to wash face.
							•	•	•	•	**Needs step-by-step cueing during grooming tasks.** ☑ Needs someone with them throughout the grooming process telling them each step of the process. ☑ Needs step-by-step cueing to brush teeth. ☑ Needs step-by-step cueing to wash hands. ☑ Needs step-by-step cueing to wash face. ⃠ Needs reminders to groom self.

GROOMING

6.9 Dressing

The ability to dress as necessary. This includes the fine motor coordination for buttons and zippers. However, difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
•	•	•									**Has physical characteristics that make dressing very difficult-- such as contractures, extreme hypotonia or extreme hypertonia.** ☑ This can include difficulty with baby's diaper changes.
			•	•	•						**Does not assist with dressing, such as helping to place arms in sleeves or legs into pants.**
				•							**Unable to pull off hats, socks, and mittens.** ☑ Unable to take off all of these items. ☑ Needs someone to get the item partially off, then the child is considered unable to pull off item. ⃠ Can take off any one of the mentioned items (e.g., can pull off socks but not hats or mittens).
					•						**Unable to undress self independently.** ☑ Unable to take off any one item that is worn on a regular basis. ⃠ Unable to undo buttons but can pull buttoned shirts off over head. ⃠ Unable to undo fasteners on the backs of clothing.
						•	•	•	•	•	**Needs physical assistance with getting clothing on. This does not include fasteners such as buttons, zippers and snaps.** At this age it is expected that typically developing children can dress themselves. ☑ A parent/caregiver needs to hold pants while a child steps into them or help pull a shirt over the child's head. ☑ Puts clothing on by self but clothing is inside out, or backwards (not including underwear), or shoes are on the wrong feet. ⃠ Can dress independently but needs help with fine tuning (e.g. tucking shirt in, zipping pants, buttoning shirt).

6.10 Eating

The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⦸ **Indicates that the item on the functional screen should NOT be checked.**
•	•	•	•	•	•	•					**Receives tube feedings or TPN.**
							•	•	•	•	**Needs help with tube feedings or TPN.** ⦸ A teen independently self-administers tube feedings. In this case, you would check "Receives tube feedings or TPN," but not "receives help with" them.
•	•	•	•	•	•	•					**Requires more than three hours per day for feeding or eating.** ☑ Can feed self but is so resistant or slow that the child is at risk of tube feedings to obtain adequate nutrition. ⦸ Toddlers who nibble all day long. ⦸ Children who are picky eaters or eat "junk food" all day. ⦸ Food preparation time for special diets.
•	•	•									**Requires more than one hour per feeding.** ☑ Takes a great deal of time to feed orally (nurse or bottle fed). ⦸ Is tube fed.
					•	•	•	•	•	•	**Needs to be fed.** ☑ Cannot feed self enough (orally) to obtain adequate nutrition. ⦸ Is tube fed. Instead, check "Receives tube feedings or TPN," and, if true, "Needs help with tube feedings or TPN." ⦸ Able to feed self but makes a mess or doesn't use utensils so the parent prefers to feed child. ⦸ Able to feed self but parent prefers to feed child .
					•	•	•	•	•	•	**Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications.** ☑ Needs to be monitored for life-threatening choking incidents. ☑ Has Prader-Willi Syndrome and all food access must be controlled. ⦸ Has current eating disorder requiring one-on-one monitoring at meals. ⦸ Avoids certain foods, gags or spits out foods due to oral sensitivities. ⦸ Parents/caregivers thicken liquids for the child and then they can be left to drink without one-on-one monitoring. ⦸ Has food cut into bite size pieces but does not require monitoring during the meal.

EATING

6.11 Toileting

The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⊘ **Indicates that the item on the functional screen should NOT be checked.**
•	•	•	•	•							**Applicable questions for the purposes of this screen have been covered on the Health-Related Services Section.**
					•						**Has no awareness of being wet or soiled.** ☑ Does not know or care that their diaper/underpants are wet or soiled.
					•						**Does not use toilet/potty chair when placed there by a caregiver.** ☑ Will sit on toilet/potty chair but does not use it to void.
						•	•				**Incontinent during the day (of bowel and/or bladder).** When one does not have physical control of bowel or bladder. When considering whether child is incontinent more than 1/3rd of the time, incontinence should be counted by days, not the number of times the child voids each day. ☑ Is incontinent once a day on school days (that's more than 1/3rd of the time). ☑ Has accidents because s/he did not get to bathroom on time. ☑ Is wet between self-cathing intervals. ⊘ Uses pull ups to have bowel movements but has control of his/her bowel. ⊘ Behavioral problems involving voiding or defecating. ⊘ Uses a catheter with some leakage.
						•					**Needs physical help (other than wiping).** ☑ Child consistently needs hands on assistance to use toilet. ⊘ Child is not able to wipe him/herself after a bowel movement but is otherwise independent in toileting.
							•	•	•	•	**Needs physical help, step-by-step cues, or a toileting schedule.** A "toileting schedule" is when other people must take the child to the toilet at regular times to reduce incontinence. This does not include a child who needs verbal reminders to use the bathroom at regular times. ☑ Parent/caregiver performs catheterization or assists the child with cathing. ☑ Needs help wiping following a bowel movement. ⊘ Requests a pull up or diaper for the purpose of defecating in it. ⊘ Can self-cath at regularly scheduled intervals. ⊘ Parent/caregiver wakes a child to urinate at the same time every night to prevent bedwetting.
							•				**Incontinent of bowel during the night.**

TOILETING

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⊘ **Indicates that the item on the functional screen should NOT be checked.**
								•	•	•	**Incontinent (of bowel and/or bladder).** When one does not have physical control of bowel or bladder. When considering whether child is incontinent more than 1/3rd of the time, incontinence should be counted by days, not the number of times the child voids each day. ☑ Is incontinent once a day on school days (that's more than 1/3rd of the time). ☑ Has accidents because s/he did not get to bathroom on time. ☑ Is wet between self-cathing intervals. ⊘ Uses pull ups to have bowel movements but has control of his/her bowel. ⊘ Behavioral problems involving voiding or defecating. ⊘ Uses a catheter with some leakage.

6.12 Mobility

The ability to move between locations in the individual's living environment. For children, this includes home and school. Mobility includes walking, crawling, or wheeling oneself around at home or at school. For eligibility purposes, mobility does not include transporting oneself between buildings or moving long distances outdoors.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
•											**Not applicable for purposes of this screen.** This option does not appear on the functional screen because young children are expected to require assistance in this category.
	•										**Unable to maintain a sitting position when placed.** ☑ Pillows or props are used and the child still cannot support their own trunk ⃠ Pillows or props are used and the child is able to maintain a sitting position.
	•										**Unable to move self by rolling, crawling, or creeping.** ☑ Cannot move self. ⃠ Can do one but not the others.
		•									**Unable to pull to stand.**
		•									**Unable to sit alone.** ☑ Needs pillows or props to support the child in a seated position. ⃠ Needs parent or caregiver to place child in a seated position.
		•									**Unable to creep or crawl**. ⃠ Able to creep but not crawl. ⃠ Able to crawl but not creep.
		•	•	•							**Requires a stander or someone to support the child's weight in a standing position.** ☑ Cannot stand even if they have something to hold onto. ☑ Does not have the strength in their legs to support their own weight. ⃠ Can support their own weight, for example, cruising on furniture or using a walker.
			•	•	•	•	•	•	•	•	**Uses a wheelchair or other mobility device not including a single cane.** ☑ Uses a mobility device that is generic or specialized equipment to compensate for a physical impairment in mobility. ☑ Uses a wheelchair or walker. ☑ Uses generic equipment (e.g., a stroller), <u>only</u> if it is used to compensate for the child's physical mobility impairment. ⃠ Uses AFOs, braces, or a single cane.

MOBILITY

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
			•								**Unable to take steps holding on to furniture**. ☑ Can pull to stand with the aid of furniture but then cannot take a step. ⃠ Can take a small number of steps. ⃠ Cannot pull to stand. Instead you would check “Requires a stander or someone to support the child’s weight in a standing position."
				•	•	•	•	•	•	•	**Does not walk or needs physical help to walk**. ☑ Needs to hold someone’s hand in order to walk. ⃠ Can cruise holding onto furniture. ⃠ Walks independently with equipment such as a walker.

6.13 Transfers

Does not include bathtub or shower. The physical ability to move between surfaces: e.g., from bed/chair to wheelchair, walker or standing position. This excludes transfers into bathtub or shower or on and off the toilet, because those are captured in bathing and toileting ADLs.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⊘ **Indicates that the item on the functional screen should NOT be checked.**
•	•	•	•								**Not applicable for purposes of this screen.** This option does not appear on the functional screen because young children are expected to require assistance in this category.
				•							**Needs to be transferred.**
					•	•	•	•	•	•	**Needs physical help with transfers.**
					•	•	•	•	•	•	**Uses a mechanical lift.** ☑ Uses a mechanical lift with or without assistance.

TRANSFERS

6.14 Communication

Hearing Impairments
Many of the questions in this category are related to auditory/verbal communication. If a child has a known hearing impairment some interpretation will be required to answer the questions correctly. Please consider the child's primary method of communication. If they communicate through sign language due to a hearing impairment, then complete the questions with that understanding. For example, for a child who is deaf, when asked "Does not use more than 10 meaningful words or word approximations," you would inquire if they can sign 10 words. That would not be the case for example for a child with Down syndrome who has a speech delay and is enhancing their communication with sign language. For that child, their primary method of communication is still verbal.

Non-Verbal / Use of Communication Devices
Many of the questions in this category are related to auditory/verbal communication. If a child has a known significant language disorder that has resulted in the use of an alternative communication system, some interpretation will be required to answer the questions correctly. Please consider the child's primary method of communication. If they communicate using a communication devise, then complete the questions with that understanding. For example, for a child who is non-verbal and uses a Dynamite to express themselves, when asked "Does not join familiar words into phrases (e.g., "me drink," "red truck")," you would inquire if they are combining words on their Dynamite. Also check "Uses adaptive equipment to communicate" if the child is 4 years old or older.

Emerging Skills
The CLTS-FS is trying to capture mastered skills. If a skill listed has been mastered then check accordingly. If the skill is starting to emerge and parents/caregivers can report that they have witnessed the skill but only a few times, do not consider the skill mastered. This is especially evident in Communication and Learning.

Assessment of 35% delay
Some of the IADLs have a box for "Assessment or evaluation within the last three (or 6 or 12) months indicates greater than 35% delay or two standard deviations…" Screeners do not always have documentation to substantiate this item. Even when a child's delays are obviously significant, they are not usually documented in these precise terms. This item is only a "shortcut" in case you see documentation in these terms. Do not worry if you cannot check this item. It is essentially superfluous to all the other IADL descriptions of a child's functioning. Make special note of the number of months associated with each question (it varies based on the age of the child).

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ Indicates that the item on the functional screen should be checked. ⊘ Indicates that the item on the functional screen should NOT be checked.
•	•										**Assessment or evaluation within the last <u>3 months</u> indicates greater than 25% delay or 1.5 Standard Deviations (SD) below the mean on a norm referenced tool in receptive and expressive language.**
		•	•	•							**Assessment or evaluation within the last <u>6 months</u> indicates that child has greater than a 35% delay or 2 Standard Deviations (SD) below the mean on a norm referenced tool in receptive and expressive language.**

COMMUNICATION

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
					•	•	•	•	•	•	**Assessment or evaluation within the last <u>year</u> indicates that child has greater than a 35% delay or 2 Standard Deviations (SD) below the mean on a norm referenced tool in receptive and expressive language.**
•	•										**Does not make any vocal sounds (includes crying).** ☑ Cannot cry out for help (e.g., a child with a tracheostomy).
	•										**Does not respond when spoken to.** ☑ Does not turn head in the direction of the speaker. ☑ Does not engage any level of eye contact when spoken to.
	•	•									**Does not express needs through vocal, visual, or gesture exchange.** ☑ Does not convey needs to parent/caregiver. ⃠ Expresses needs in only one way (e.g., gesture but not vocal or visual).
		•									**Does not respond to own name.** Name may be spoken or signed. ☑ Does not react (e.g., turn head, engage eye contact) to their own name.
		•	•								**Does not respond to simple requests (e.g., no, stop, all done).** ☑ Does not seem to notice that someone has said (signed) something to them. ⃠ Understands the request but does not comply.
			•	•							**Does not use more than 10 meaningful words or word approximations.** ☑ Only says words when repeating what other's say. Does not use spontaneous speech. ⃠ People familiar with the child understands the word approximations. ⃠ Is not understood by strangers. ⃠ Uses word approximations such as "bah" for "bottle."
				•							**Does not join familiar words into phrases (e.g., "me drink," "red truck").** ☑ Uses only phrases that have no meaning to the people familiar to the child. For example, "bottle truck," "baa quack." ☑ Uses primarily single words to communicate although parents/caregivers have heard a few two-word phrases emerging.
				•	•	•					**Does not follow a series of two simple related instructions.** ☑ Follows through with one instruction and cannot retain second instruction. ☑ Child is asked to "go to your room and bring back your bunny" and gets to their room and does not come back with their bunny. ☑ Does not follow any instructions.

COMMUNICATION

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
					•	•	•	•	•	•	**Uses adaptive equipment to communicate.** This means that the child uses adaptive equipment to communicate more than one-third of the time (i.e., the child uses adaptive equipment as their primary form of communication). ☑ Uses PEC cards, computerized communication system or any other devices if they are used to compensate for the child's speech impairment. ☑ The parents/caregivers prefer another method, are hesitant to use, or cannot afford adaptive equipment. ⃠ Communicates using sign language.
					•						**Does not use at least 50 words.** ⃠ Uses 50 or more words but can only be understood by people familiar with the child.
					•						**Does not use "my" or "mine" to indicate possession.**
						•					**Does not know at least 3 prepositions (e.g., in, on, under).** ⃠ Uses at least 3 prepositions but not the ones listed in the example.
						•					**Does not combine 3 or more words into a meaningful sentence.** ☑ Uses primarily single words to communicate although parents/caregivers have heard three word phrases emerging. ⃠ Can only be understood by familiar people.
						•					**Does not answer "what" or "where" questions.** ⃠ Answers simple questions like "Where is your nose?" or "What is that?" ⃠ Answers either "what" questions or "where" questions but not both.
							•	•	•	•	**Does not follow a series of 3 unrelated instructions.** ☑ <u>Cannot follow</u> 3 <u>unrelated</u> instructions such as, "Turn off the TV, put your books away and make yourself a snack" even if s/he is able to follow a series of 3 <u>related</u> instructions such as, "Collect the garbage from upstairs, tie the bags tight and put them on the curb." ⃠ Able to follow non-sequential instructions such as, "Don't forget your lunch, go to Johnny's house after school and remember we are going to the YMCA tonight."
							•	•	•	•	**Is not understood by strangers.** ⃠ Able to communicate messages to others even though some words may be unclear. ⃠ Child is fluent in ASL or signed English.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⊘ **Indicates that the item on the functional screen should NOT be checked.**
							•	•	•	•	**Does not engage in reciprocal conversation.** ☑ Only responds to questions when asked. ☑ Only uses echolalia type speech (i.e., only mimics what others say). ☑ Only uses rote answers to specific questions. ☑ Does not initiate or respond to dialog with another person at an age appropriate level. ⊘ Communication is responsive to other individuals' comments.
								•			**Does not understand the meaning of at least 10 written words.** ☑ Does not understand at least 10 words often seen in community settings such as no, on/off, stop, boys, girls, exit.
								•			**Is two or more grade levels behind in reading or writing.** ☑ Parent report only, no documentation.
									•	•	**Is three or more grade levels behind in reading or writing.** ☑ Parent report only, no documentation.

6.15 Learning

Compromising Impairments
Under the category of Learning, the CLTS-FS is capturing cognitive development. The questions have been stated in broad terms to try to account for different developmental issues affecting children. If a child has limitations that mask their cognitive development, try to determine the actual cognitive ability. If a child has a significant vision impairment, has a significant hearing impairment, or has a complex physical disability that compromises the child's ability to demonstrate their intelligence, consider the question in light of that impairment. For example, "Does not seek objects that were hidden" is a question asked for a 13-18 month old child. If a child is blind, this skill may not be possible to measure. If a child has a physical disability that limits their movement, we may still be able to tell that the child understands object permanence by seeing if they continue to look in the direction of a toy that was hidden or start looking away as if the toy disappeared. When the child's compromising impairments result in not being able to adequately measure their cognitive impairment, make note of the situation in the notes section on that page and contact state staff for further assistance.

Emerging Skills
The CLTS-FS is trying to capture mastered skills. If a skill listed has been mastered then check accordingly. If the skill is starting to emerge and parents/caregivers can report that they have witnessed the skill but only a few times, do not consider the skill mastered. This is especially evident in Communication and Learning.

Assessment of 35% delay
Some of the IADLs have a box for "Assessment or evaluation within the last six (or 12) months indicates greater than 35% delay or two standard deviations…" Screeners do not always have documentation to substantiate this item. Even when a child's delays are obviously significant, they are not usually documented in these precise terms. This item is only a "shortcut" in case you see documentation in these terms. Do not worry if you cannot check this item. It is essentially superfluous to all the other IADL descriptions of a child's functioning. Make special note of the number of months associated with each question (it varies based on the age of the child).

IQ Test Scores
We are forced to use full-scale IQ scores as a way to address the over-use and under-use of the diagnosis of mental retardation (MR). We are aware of the limitations of IQ testing. The federal definition of MR is a full-scale IQ below 70. Federal guidelines do acknowledge an IQ score error range of 5 points. We have chosen to use 75 as a "cut-off" point instead of 70 in recognition of that error range.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ Indicates that the item on the functional screen should be checked. ⊘ Indicates that the item on the functional screen should NOT be checked.
•	•										**Assessment or evaluation within the last <u>3 months</u> indicates greater than 25% delay or 1.5 Standard Deviations (SD) below the mean on a norm referenced tool in cognitive development.**
		•	•	•							**Assessment or evaluation within the last <u>6 months</u> indicates greater than 35% delay or 2 Standard Deviations (SD) below the mean on norm referenced tool in cognitive development.**

LEARNING

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
					•	•	•	•	•	•	**Assessment or evaluation within the last <u>year</u> indicates greater than 35% delay or 2 Standard Deviations (SD) below the mean on norm referenced tool in cognitive development.**
						•	•	•	•	•	**Has a full scale IQ score of 75 or less.**
•	•										**Does not show an interest in people or objects.**
•	•										**Is not soothed when needs are met.** ☑ No matter what is offered (food, diaper change, hugs and snuggles) the child is not soothed. ☑ Cries throughout the day and night without any predictable pattern. ⃠ Is a "colicky" or "fussy" baby, but can be soothed with some effort to meet needs. ⃠ Is fussy for a fairly predictable period of almost every day.
		•									**Does not distinguish between familiar persons and strangers.** ☑ Responds the same regardless who picks up the child. ☑ Shows no preference when handed to a stranger or a parent/caregiver.
		•									**Does not seek objects that were hidden.** This is a common milestone of typical development called <u>object permanence</u>. Intended to determine if a child understands that an object still exists even if it disappears from sight. ☑ Once an object disappears from sight, the child does not show any indication that they understand that the object itself still exists. ⃠ Follows an object with an eye gaze as it is put it under a blanket and then continues to look at the blanket. This is important to consider for children with physical limitations.
		•	•								**Does not imitate gestures or activities (e.g., wave bye-bye, clap hands, make faces).**
		•	•								**Does not interact with environment to make something specific happen.** ☑ If given a toy that lights up when a button is pushed, the child does not seek to have the button pushed. ⃠ Routinely takes a parent/caregiver to refrigerator to indicate hunger/thirst. ⃠ Child with quadriplegia asks people to get things for him.
			•								**Does not know any body parts (e.g., "Where's your nose?").** ⃠ Only knows one body part.
				•	•						**Does not connect a familiar action with an expected outcome (e.g., starting the water means a bath or shower).** ☑ Does not know that they are about to go outside when someone brings them a coat.
				•							**Does not know at least 3 body parts.** ⃠ Only knows 3 parts of the face.

LEARNING

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
				•							**Does not match circles or squares.** ☑ If given a wooden puzzle with three pieces, a square, circle and a triangle, the child cannot place in the circle (or square) piece correctly. ⃠ Child with quadriplegia can match circles or squares by sight.
					•						**Does not group objects by category (e.g., dogs and cats are animals).** Other examples include: fruits and vegetables are foods, balls and blocks are toys, squares and triangles are shapes, cars and trucks are vehicles.
					•						**Does not identify objects in pictures.** ☑ Does not identify a tree in the picture when asked "where's the tree?" ☑ When looking at a family photo the child does not identify a person by name or relationship (Billy, Mommy). ☑ Able to identify objects in the home but not in picture books or photographs. This question is to capture the learning milestone that pictures represent things. ⃠ Child cannot see pictures due to a visual impairment.
					•						**Does not maintain an attention span of at least three minutes for an enjoyable activity (not including self-stimulating behavior).**
						•					**Does not match identical objects or pictures.** Examples include: Memory games, picking out two identical pictures of a cow from a group of animal pictures, picking out two bananas from a bowl of fruit, matching socks in the laundry.
						•					**Does not know 3 colors or shapes.** ⃠ Can name 3 colors but not any shapes, or, can name 3 shapes but no colors.
						•					**Does not count 3 objects.** ☑ Can only repeat counting when done by another person or TV show. ☑ Can count to three or even higher but does not know that numbers represent a certain quantity or things.
							•				**Does not know common opposites (e.g., big-little, more-less, hard-soft).** Other examples include: in-out, rough-smooth, hot-cold, tall-short.
							•				**Does not understand sequencing (e.g., breakfast, lunch, dinner).** Other examples include: summer-fall-winter-spring, now-soon-later, first-second-third.
							•				**Does not follow rules to simple games.** These can be very simple games such as board games, T-ball, marbles, cards - any game that has standardized rules. Does not include playing toddler games such as Patty-cake. Following rules includes turn taking as well as other factors present in games (knowing that one must move a playing piece, the idea of a winner, etc). ⃠ Child understands rules but might make up new ones or adjust rules.

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ **Indicates that the item on the functional screen should be checked.** ⊘ **Indicates that the item on the functional screen should NOT be checked.**
								•			**Is two or more grade levels behind in two academic subjects other than reading or writing.** ☑ Parent report only, no documentation.
								•			**Does not know abstract concepts (e.g., outer space, the ocean, dinosaurs).**
								•			**Does not tell time.** Can be either on a digital or analog clock.
								•			**Does not identify coins by name.** By name means penny, nickel, dime, quarter. ☑ Able to identify some but not all. ⊘ Able to identify names of coins but not their value.
									•	•	**Is three or more grade levels behind in two academic subjects other than reading or writing.** ☑ Parent report only, no documentation.

6.16 Meal Preparation

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ Indicates that the item on the functional screen should be checked. ⊘ Indicates that the item on the functional screen should NOT be checked.
										•	**Needs help making simple meals for self.**

6.17 Money Management

0-6 mos	7-12 mos	13-18 mos	19-24 mos	25-36 mos	3-4 yrs	4-6 yrs	6-9 yrs	9-13 yrs	14-17 yrs	18 yrs +	☑ Indicates that the item on the functional screen should be checked. ⊘ Indicates that the item on the functional screen should NOT be checked.
										•	**Needs help with managing money.**

6.18 Duration of Needs

"Are any ADL/IADL functional impairments expected to last for at least one year from the date of screening?"

- ☐ **Yes**
- ☐ **No**
- ☐ **No ADL/IADLs have been checked**

For eligibility for long-term support programs, the child's need for help or equipment (i.e., her functional impairments) must be long-term. For any ADL/IADL items checked, screeners are asked to indicate whether any of the functional impairments are expected to last for at least one year from date of screening. Health care providers regularly make such predictions. If some of the functional impairments are not expected to last but one or more is, then check "yes" for this question. If you are not clear about the duration, you can seek additional information. When the expected duration is not clear, check "Yes."

The screener should check "No" if the child has cancer, an illness or surgery that resulted in higher needs than normal. This is especially true if the child had typical functional skills before this acute episode.

Example:
Carlos is a 2-month old with congenital heart defects. He is expected to have surgery next month and is expected to recover and regain full functioning within three months after that. Carlos is not eligible for long-term support programs.

6.19 Expected Decline in Functioning

"Child has a verified diagnosis that is expected to cause more substantial long-term functional impairments within one year: (Check all that apply.)"

- ☐ **Self-Care**
- ☐ **Mobility**
- ☐ **Learning**
- ☐ **Communication**

This is an important question on the Functional Screen that is intended to work for the following situations:

- **Serious conditions diagnosed in young infants:** e.g., Down Syndrome, Tay Sachs, degenerative neurological disorders. It may be too early to see any developmental delays or functional impairments yet, but some diagnoses are known to cause substantial impairments as the infant grows.
- **Newly diagnosed conditions in children of any age:** e.g., brain tumor.
- **Expected deterioration ("more substantial impairments") in existing condition, with or without any current ADL/IADL impairments:** e.g., boys with muscular dystrophy who are just entering adolescence may be expected to have a substantial increase in functional impairments. Such a child may be expected to need a wheelchair within a year.

In all of these cases, the impairments should be expected to occur within a year from the date of screening. Also, the expected impairments should be "**long-term"** that is, they should be expected to last for more than six months once they do appear. For example, if a child will have surgery and then a body-cast for three months, you should not check this box because the expected impairments will last less than six months and is considered an acute episode.

Screeners are not expected to make clinical or nursing judgment about whether a child's functioning will deteriorate. Screeners would check that child has a "verified diagnosis that is expected to cause more substantial long-term functional impairments within one year" only if:

- Medical records indicate or health professionals report that the criterion is true.
- The parents report that MDs have informed them that the criterion is true.
  As with diagnoses, parents' own opinions are not recorded, but parents' reports of what qualified professionals have told them can be recorded.
- A screener's expertise allows them to know, based on child's age and diagnosis, that the child will have substantial functional decline in the next year.

Many screeners do not have the expertise to know if a particular condition will cause substantial lasting impairments within a year. The screener will want to review the case with a physician or a nurse who will be better able to predict the child's functional impairments over the next year.

MODULE #7: Work and School

7.1 School

Does the child's physical health or stamina level cause child to miss over 50% of school or classes or to require home education?
Unlike most questions on the CLTS-FS, this one focuses on **physical conditions** only. Problems related to mental illness or emotional disturbance are captured in the behavior section of the Functional Screen, but this question is needed for children with physical disabilities who might be able to do their ADLs/IADLs but are unable to participate in school due to their physical condition.

This includes children who go to school but miss more than half of their classes due to therapies, treatments, or rest periods needed due to their condition. This does not include children who are present at school but have difficulties participating as a result of medication side effects (such as sedation).

Home-schooling may be a choice unrelated to the child's condition. Screeners will need to ask whether the child is being home-schooled because their physical health or stamina makes them unable to attend school most of the time.

If the child is not currently in school because of summer vacation or school holiday, but the current condition is such that the child would miss 50% if school were in session, you would check yes.

If the child has not missed school, but has a new diagnosis or an increase in the child's health needs, that will most likely cause them to miss 50% because of their treatment or condition, you would check yes.

If for any reason you question the reason for home schooling, follow up with a qualified medical professional or a public school to verify the child's physical health or stamina needs.

Is child currently attending high school?
If the child is between grades at school (for example it is June and the child has finished eighth grade and will enter high school in the fall) you will enter the anticipated grade.

For the purposes of the screen, ninth through twelfth grade are considered high school.

What year is the child expected to leave school?
For most children, this will be the anticipated graduation date. However, some children will graduate but not leave high school. In this situation you will use the anticipated date they will actually leave school. For many children this will be at age 21 years.

Transition related supports provided to the child
This question does not affect eligibility. It is included in the CLTS-FS to help promote systems improvements for children age 14-18 and their parents. Check services the child has received or currently has.

7.2 Employment

Current employment status
This question is mostly to assist with job-related systems improvements.

"Currently employed" means that the person has a job and is actually working (not on medical leave).

Need for assistance to work
Screeners may need to ask some questions to distinguish the person's actual needs from services that may be being provided.

Example: Sandy works in a sheltered workshop but really doesn't need help more than once a week. Screener should check that help is needed weekly, even though staff is present every day.

MODULE #8: Health-Related Services

8.1 Overview of the Health-Related Services (HRS) Table

- The HRS Table assigns "weights" to each check box in complex ways.

- There are many ways to get a Level of Care (LOC); even though one task for a child is not on the table or you cannot check it, the child may get a LOC some other way.

- The screen logic can "see" if a child is unable to report problems, and for some HRS tasks, will assign heavier "weights" for that child. For example, a tracheostomy in a baby requires much more oversight than a tracheostomy in a healthy teenager who can report problems and get help if needed.

- **Medications** (except for intravenous ones) are absent from the HRS section. Of course giving and monitoring medications are very important, often life-saving, tasks for children. Because these tasks are almost universally done for **all** children, they are not helpful in distinguishing nursing-home eligible children from non-eligible ones. It is difficult to remove subjectivity between "important," "dangerous," "life-saving" medications from "routine" ones, and the line cannot be drawn between routes of administration.

- **Seizures** are not included in the CLTS-FS. *Instead*, the first row of the HRS Table, which looks for life-threatening emergencies, is intended to distinguish (as objectively as possible) the "medically fragile" (hospital or nursing home eligible) children from others.

- Similar issues arose with other tasks that may or may not make a child eligible. For example, therapies, therapy follow-through exercises, and wound and special skin care. They usually do not in themselves make a child Hospital or Nursing Home eligible. At times they can be so extensive and time-consuming that they would make a child Hospital or Nursing Home eligible. For now, the CLTS-FS uses time per day as the objective criteria. Further testing may indicate some revisions.

In summary, the HRS Table may be another place (like ADLs/IADLs) where a screener feels they cannot fully describe a child. That is because the goal is to seek **accurate** results with the **briefest** possible screen. Whatever could not objectively determine LOC was left out. Remember that a Functional Screen for a child will be looked at **in total when calculating eligibility**.

Two children could have the same skilled nursing needs, but one might get a Nursing Home LOC and one not. That is because one did not have the **functional impairments** that are needed to be considered Nursing Home eligible.

Also, two children could have the same skilled nursing needs, but one may be expected to have those needs long-term (for more than six more months), while the other may not. The second

child would not be eligible for **long-term support** programs, no matter how severe their short-term medical needs are.

8.2 Medical or Skilled Nursing Needs

This table lists conditions or tasks without frequency of help needed. There may be "fuzziness" in whether tasks take "One hour a day or less" or "More than 1 hr/day." Ask a few additional questions to get as accurate as possible. Brief sessions can be added up---for instance, 15 minutes 6 times a day = 90 minutes per day.

Medical or Skilled Nursing Needs (Check all that Apply)	**☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.**
Rehabilitation program for brain injury or coma – minimum 15 hours/week	☑ Child has comprehensive home rehabilitation program to address physical, social and psychological needs to follow recent discharge from a rehabilitation hospital. ⃠ Child has finished in-patient brain injury rehabilitation and is receiving therapies at home and/or school. ⃠ Child had a brain injury years ago and receives on-going therapies at home and school.
Positioning every 2 hours (unable to turn self)	☑ Child has quadriplegia and cannot turn himself over in bed. (Would expect child to need help with ADLs as well.) ☑ Child needs someone to reposition her in a wheelchair and in bed to prevent skin breakdown. ⃠ Child can reposition herself somewhat in a wheelchair and can turn herself in bed. ⃠ Child needs repositioning but less frequent than every 2 hours.
Recurrent Cancer	☑ "Recurrent cancer" is written in child's records. ☑ Parent can clearly state cancer is "recurrent," or that cancer had gone away and has come back. ☑ Child was in remission but now cancer is growing again regardless of how much time has passed. ☑ Child completed chemotherapy last year, but the cancer has come back. ☑ Child has had radiation therapy, but the cancer has spread to other parts of the body ("metastasized"). ☑ A new kind of cancer has developed regardless of how much time has passed since the last cancer was treated. ⃠ Child is still in first series of treatment. ⃠ Screener is not sure whether cancer is "recurrent" or still in first round of treatment.

Medical or Skilled Nursing Needs (Check all that Apply)	**☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.**
Stage IV Cancer	**Stage IV ("four") Cancer is particularly life threatening. Typically with Stage IV Cancer, chemotherapy or radiation treatment is provided to reduce pain and suffering rather than as an anticipated cure.** ☑ Parents clearly state that MD told them the child has "Stage Four" cancer. ☑ "Stage IV" is written in medical records. ☑ A healthcare provider tells you that the child has Stage IV cancer. ⃠ Parent says child's prognosis is poor, but has not heard of "Stage Four" and you do not see it in records.
Tracheostomy	☑ Child has a current tracheostomy ("breathing hole" through front of throat). ⃠ Child had a tracheostomy in the past that is now almost healed closed.
Ventilator (positive pressure)	☑ Child continually uses a mechanical volume ventilator—one that forces air into the lungs. ☑ Child uses a mechanical volume ventilator only while sleeping. ⃠ Child uses "C-PAP" or "BI-PAP" (which provides extra pressure but does not force air into lungs).
PT, OT, OR SLP by therapist (does not include behavioral problems)	☑ Child receives PT (physical therapy), OT (occupational therapy), or SLP (speech language pathology) done by a licensed therapist or an appropriately supervised therapy aide. ☑ PT, OT, or SLP has been recommended but child has not received it yet. ⃠ In-home autism program. ⃠ Behavioral therapies. ⃠ Exercises done by someone other than a therapist or therapy aide. ⃠ Child sees a therapist less than once a month. **"Less than 6 sessions/week" OR "6 or more sessions/week"** • Add all three therapy disciplines to count the number of sessions per week. • A joint therapy session (e.g., PT and OT together at same time) can be counted as two sessions. • Group therapy sessions can be counted as long as led by a qualified professional. • Therapy can be provided at any location - home, school, or clinic. • A session must be at least 15 minutes long to be counted.

Medical or Skilled Nursing Needs (Check all that Apply)	**☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.**
PT, OT, SLP therapy follow-through: Exercises, sensory stim, stander, serial splinting/casting, braces, orthotics	**This item captures a mix of things, all of which should be established by a physician or licensed therapist. Follow the definitions provided below; do not add anything.** **"Exercises"** ☑ Records indicate the exercises are "PT, OT, SLP therapy follow-through." ☑ Exercises are part of an individualized treatment plan developed from a therapist's full assessment, and therapist(s) taught caregivers what to do. ☑ Parents continue to do therapy exercises for their child, as instructed by therapists, although they and child no longer require therapy oversight at this time. ⃠ The exercises are general things like taking a walk or riding a bike. **"Sensory stimulation"** ☑ A therapist has taught the family or school staff to do sensory stim for child with tactile sensitivity. **"Stander"** (A special positioning device to place a child in an upright position for weight bearing) ☑ Child is put into a stander for 10 minutes a day at school. ⃠ Child has a stander but doesn't use it anymore. **"Serial splinting or serial casting"** ☑ Child's parents are doing "serial splinting"—applying specially adjusted splints or bi-valved casts to progressively stretch the child's muscles to prevent contractures and facilitate treatment ⃠ Child has worn the same splints (e.g., AFOs, KAFOs) for months to prevent contractures. This is not "serial splinting." ⃠ Child is in a total body cast. **"Braces, orthodics"** ☑ Child is unable and parents/caregivers must apply braces or orthodics and monitor for skin and nerve involvement.

Medical or Skilled Nursing Needs (Check all that Apply)	**☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.**
Wound, site care or special skin care	**"Wound care"** ☑ Child has special gel dressing (e.g., Una boot, algiderm, duoderm, etc.) that is changed every 7 days. ☑ Parents are changing gauze dressings 2 or 3 times a day. ☑ Mom changes dressings twice a day and nurse cleans wound once a week. ⃠ Mom is applying "Band-Aids." **"Site or Special skin care"** ☑ Child requires skilled site care of an ostomy, catheter or central venous line (IV). ☑ Child has a rare and severe skin disease that creates open skin requiring medicine and wrapping. ⃠ Child receives lotions or ointments applied to intact skin.

8.3 Definitions for Particular Health-Related Services

See "8.4 Frequency of Help/Services Needed" for instructions on how to fill in the frequency rows on the HRS table.

Medical or Skilled Nursing Need	**☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.**
Child has life-threatening incidents with sudden onset	**This row is to include children who, if they were hospitalized, would probably be in *intensive care*. Life-threatening incidents in the strictest sense of respiratory/cardiac arrest.** ☑ A premature baby was sent home from hospital six weeks ago with oxygen and apnea monitors that alarm if he stops breathing. He continues to have significant respiratory problems. He is on oxygen, but he needs the oxygen to be turned up sometimes when he gets cyanotic (turning grey from lack of oxygen). This happens almost every time he nurses or cries. He can only tolerate half a feeding at a time, because he gets too low on oxygen. His apnea alarm continued to go off 3 to 6 times a week through last week, requiring stimulation to get him to breathe. His caregivers check his "blood oxygen saturations" to adjust the oxygen doses several times a day. For him, you check "Oxygen..." 2 or more times/day AND you also check this 1st row, "Child has life-threatening incidents with sudden onset" more than 2 times/day. ☑ Child has uncontrolled seizure disorder and has stopped breathing several times during seizures. He requires private duty nurses and has to be constantly monitored by someone able to assess his respiratory status during a seizure. Several times he has needed not only oxygen, but also to be "bagged" (oxygen forced into his lungs). The incidents come on suddenly and he would die without these interventions. ⃠ A premature baby was sent home from hospital 6 weeks ago with oxygen and apnea monitors that alarm if the she stops breathing. She is now doing quite well. She is still on low-dose oxygen while she sleeps, but she has not needed it more than that for over a month. Her apnea alarm has not gone off for five weeks. For her, you check Oxygen 2 or more times/day. You do not check this row for life-threatening incidents. ⃠ Child has an uncontrolled seizure disorder. He has to wear a helmet to prevent head injuries during seizures. His family and school staff often administer Valium during his longer seizures. These seizures occur suddenly and at unpredictable times, so he cannot be left alone. However, he does not have any respiratory problems during seizures; they are not life-threatening incidents in the strictest sense of respiratory/cardiac arrest. The interventions needed for them are fairly basic and the outcomes are predictable. This row does not apply. ⃠ Child requires constant attention to prevent him from running into traffic or other life-threatening behaviors of sudden onset. This row is for emergency skilled nursing tasks. Safety and behavior risks are captured elsewhere in the CLTS FS.

Medical or Skilled Nursing Need	☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.
	⃠ Child is dying from a terminal condition, and cares are to maintain comfort. This row is for emergency skilled nursing tasks of sudden onset.
BOWEL or OSTOMY - Related <u>SKILLED</u> Tasks (Digital Stim, Changing Wafer, Irrigation) Does not include site care.	☑ Mom reports that child receives one or more of the treatments listed in this row. ☑ Parents do "skilled" tasks include changing the wafer (which adheres to the skin and needs to be cut to proper size to avoid skin breakdown around the ostomy), and irrigations. ⃠ Child receives suppositories, laxatives, or other medications. ⃠ Child is on a "toileting schedule" but has none of tasks listed in the row. ⃠ Someone empties the ostomy bag a few times a day. (This is not a skilled task.) ⃠ Child has urinary ostomy from the bladder. (See Urinary Catheter row.)
DIALYSIS (hemodialysis or peritoneal, in home or at clinic)	**Sometimes dialysis is only needed a few times; be sure to confirm the duration of over six months.** Dialysis is usually every other day, or three days a week. That should be the frequency checked for this row; do not check higher frequencies for general monitoring of blood pressure, fluid and diet, etc. ☑ Child goes to a dialysis clinic every other day. (Check "4-7 days/week" frequency.) ☑ Home health nurse or parents administer "peritoneal dialysis" every night. (Check "2 or more times/day" frequency for hooking up and disconnecting the dialysis system.) ⃠ Site care and dressings to the dialysis shunt (an IV-like line for access to blood vessels) is captured in the wound care row, not here.
IVs - peripheral or central lines - fluids, medications, transfusions. Does not include site care.	☑ Child goes to outpatient hospital or clinic to receive IV treatments. ☑ Parent flushes child's central line once a day. *Definition: "flush." If an IV does not have fluids dripping in, it needs a "flush"- a tiny injection of blood thinner to keep it from clotting closed.*
OXYGEN and/or deep SUCTIONING – With Oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.	☑ "Deep" suctioning (down the back of the throat into the windpipe) is being done. ☑ Child wears oxygen while napping and overnight. Parent needs to apply it. (Check 2 or more times/day box.) ☑ Child gets short of breath easily, and needs someone to monitor for that and apply oxygen if she needs it. Over the past few months, she has needed oxygen on average more than half the days, and each day she needs it, it is several times each day. 2 or more times a day is the most accurate average frequency for her. ☑ Baby is on oxygen and needs continual monitoring of it. (Check 2 or more times a day.) ⃠ "Oral" or pharyngeal suctioning (i.e., just in the mouth) is being done. ⃠ Bulb suctioning in infant's nostrils. ⃠ The oxygen vendor's trips (usually every few weeks) to provide new tanks.

Medical or Skilled Nursing Need	☑ Indicates that the item on the functional screen should be checked. ⃠ Indicates that the item on the functional screen should NOT be checked.
RESPIRATORY TREATMENTS: Chest PT, C-PAP, Bi-PAP, IPPB treatments (does NOT include inhalers or nebulizers)	**Use this row to record frequency for respiratory treatments such as "C-PAP" or "Bi-PAP" and chest physiotherapy and postural drainage.** ☑ Child receives chest PT and respiratory therapy from a respiratory therapist. *Definition: "Chest PT" is chest physiotherapy to help move mucous up out of the lungs. It includes someone clapping on the child's back, or vests or machines that shake or tap on the torso.* ☑ Parents and school aides do chest PT and postural drainage twice every day. ☑ Child uses C-PAP or Bi-PAP during sleep times. *Definition: A small machine blows air into a facemask, creating extra pressure that keeps the airway and lung more open. The machine does not breathe for the child; it only creates a little extra pressure.* ☑ Child receives IPPB treatments 1 to 4 times a day depending on her breathing status. On average over the past few months, she receives IPPB treatments twice a day. (Check 2 or more times/day box.) *Definition: IPPB treatments and nebulizers involve pouring a precise amount of liquid medicine into an aerosolizing machine.* ⃠ An adult administers hand-held inhalers or aerosols.
TPN (Total Parenteral Nutrition) Does not include site care.	*Definition: This is when the child gets all their nutrition through an IV (intravenous) line. ("Parenteral" means outside the gut.)* The solution is extremely high in sugars, so there is high risk of infection and of dangerously abnormal blood sugars. TPN is always run via an IV pump for precisely controlled infusion rate. It requires close monitoring, so most of the time **you would check the "2 or more times a day" column**. ☑ Child cannot receive nutrition through intestinal system, and receives continual TPN. Check "2 or more times a day." ⃠ Child has continual IVs, which parent calls "sugar water," but the IV bags contain clear fluid, parent has never heard of "TPN," and child eats food. *This is IV fluid with just a little sugar, not complete nutrition; it is not TPN.*
TUBE FEEDINGS Does not include site care	*Definitions: NG (nasogastric) A feeding tube down the nose (or mouth) and esophagus to the stomach. NG tubes are now rare and are always temporary, due to risk of aspiration into lungs, discomfort in nose and throat, and skin breakdown of the nostrils.* *Definition: G-tube (gastrostomy) A feeding tube goes through the abdomen into the stomach.* *Definition: J-tube (jejunostomy) A feeding tube goes through the abdomen into the intestine just below the stomach.* *Definition: "Mickey" A special button apparatus to hold a G-tube in place.* You do not need to separate out every single task if several are done at the same time. Instead, indicate the general number of times a day that the tube feeding is **changed, started, and stopped**. Do not include flushing the tubing after medication administration. ☑ Young child is on a continuous tube feeding. The skilled tasks (checking for proper placement, starting a new bag of feeding, running the pump, etc.) are most often done many times a day. Check the "2 or more times a day" column.

Medical or Skilled Nursing Need	☑ **Indicates that the item on the functional screen should be checked.** ⃠ **Indicates that the item on the functional screen should NOT be checked.**
	☑ Child is starting to eat, but receives an 8-hour tube feeding 2 or 3 times a week. Check 4 to 7 times/week column. ☑ Child can eat and the G-tube is being used only for medications. The only **skilled** task is changing the G-tube every 30 days or so. Check 1-3 times/month column. ⃠ Flushing the tubing after medication administration is not counted as a skilled task.
URINARY CATHETER-RELATED *SKILLED* TASKS (straight caths, irrigations, instilling meds). Does not include site care.	*Definition: "Straight caths" or "Intermittent urinary catheterizations" are an "in & out" cathing, done usually every 4 to 8 hours.* There is a **special exception** in this row. Formerly, urinary catheters were changed every 30 days. Now, newer materials allow **some catheters to be changed only every 60 to 90 days. *For this task only,* you can check the "1 to 3 times/month"** column if someone changes the catheter, regardless of whether it is 30, 60, or 90 days (or somewhere in between). ☑ Child has a continually indwelling catheter almost all of the time. Someone else empties the bag 3 times/day. The only skilled task is to change the catheter every 60 days. Check 1 to 3 times/month. ☑ Child has a urinary catheter overnight only. If overnight, putting it in and taking it out count as 2 separate tasks. Check 2 or more times/day. ☑ 10-year-old boy with Spina Bifida self-catheterizes to empty his bladder six times a day. He has good clean technique and no problems with his self-cathing. His parents need to keep an eye out for signs of a urinary tract infection and call the doctor if they occur. The 4 to 7 times a week frequency is most accurate. ☑ Child has a suprapubic catheter (through the skin into the bladder). Parents "irrigate" (flush) the catheter twice a day. Check 2 or more times/day column. ☑ 12-year-old boy with Spina Bifida and some learning delays "sort of knows" how to catheterize himself, but he often does not do it, and his technique is not clean enough. He does not watch for or report the symptoms of urinary tract infections. Because of these problems, an adult usually needs to talk him through his self-cathing step-by-step. "Skilled nursing help" does include step-by-step cueing. Check the "2 or more times a day" box. ⃠ Routine "cath care" usually just soap and water as normal part of bathing.

8.4 Frequency of Help/Services Needed

1. For each condition or task (each row) that applies to the child, the screener will check to indicate either that the child is *independent* with the task, OR that they need skilled nursing *help from others*.

2. If the child does need skilled nursing help from others, screeners must indicate the **frequency** at which that help is needed.

Precision is important, and screeners will need to consult with healthcare providers or other experts familiar with the child and his or her needs.

☑ Indicates that the item on the functional screen should be checked.
⃠ Indicates that the item on the functional screen should <u>not</u> be checked.

Child is INDEPENDENT in Managing a Health-Related Service
☑ A child is independent in turning the oxygen on and off, taking it on and off, checking their oxygen saturation level (<u>if</u> required), and changing water bottles and tubing (**if** required).

☑ School nurse oversees girl's self-injections due to school policy, but girl is completely **independent** with the task and with monitoring for problems.

⃠ Girl knows how to check her blood sugars but usually will not unless an adult reminds her and watches her to make sure she does it.

If the child is not independent in managing a condition, place one checkmark in the column showing the most accurate frequency of "Skilled Nursing Help from Others."

Skilled Nursing Help from Others
The HRS Table looks for "Skilled Nursing Help from Others." "Skilled nursing" describes the task being done, but **not who is doing it**. Parents and other family members or school professionals are often taught to do highly skilled nursing tasks.

Some examples of situations where parents and others are trained to provide this type of care include: a mom managing a child's ventilator, a dad administering a child's IM (intramuscular) shots, and/or a Nurse's aides, school aide, or other direct care workers having been taught to do the skilled task for this child. The screen is not concerned about someone doing other "unskilled" tasks not precisely listed on the Functional Screen. Skilled nursing help includes step-by-step cueing.

Frequencies of Skilled Nursing Help
The column headings are:
- 1 to 3 times/ month
- 1 to 3 times/ week
- 4 to 7 times/ week
- 2 or more times a day

Indicate Frequency of Skilled TASKS, Not Duration of Condition
For conditions that are continually present (e.g., an indwelling urinary catheter), the checkmark should indicate the frequency of tasks related to the condition. When one condition involves more than one task, check the most frequent task with which help is needed from others. Oxygen is often worn continually; screeners should find the frequency at which the child needs help from others with particular tasks related to the oxygen.

Example: Sara has an indwelling urinary ("Foley") catheter in continually. The catheter is changed (by a nurse) every 30 days. Daily "cath care" is just soap and water as normal part of bathing and is not really considered a "health-related service" on the screen. No irrigations are needed. Sara also has a tracheostomy. Tasks related to this include having a nurse change the trach tube once every month, and a parent clean the trach site ("trach care") twice a day. Screener places TWO checkmarks: 1) Urinary catheter-related skilled tasks at "1 to 3 times/Month" and 2) Tracheostomy Care at "1-2 times/day."

Averaging Frequencies
Because it is a screen for **long-term** supports, the screen cannot just take a "snapshot" of what the child is getting for treatments today or this week, unless those treatments are expected to last for months at that frequency.

You will encounter frequencies of treatments that do not fit the columns in this table. Options are limited for brevity. Here are some guidelines for rounding off or taking averages for differing frequencies:

- If the frequency of treatments varies **over weeks or months**, select the answer that seems closest to the **average** frequency of help needed.
- If the frequency of treatments varies **day to day**, select the answer that most accurately describes their needs on the **higher** frequency days.
- If something is done less than once every month, you will not check it on the HRS table. If a task is done "every month or two": Ask how many times over the past 6 or 12 months. If that averages to almost once/month, check the "1 to 3 times/month" column.
- If the frequency of treatments averages to less than once a month, do not check it.

Multiple Frequencies of one Health-Related Service
There are often multiple frequencies for a single health-related service. As a rule of thumb, check the one with the highest frequency. For example, there will often be several skilled tasks for one IV, each at a different frequency. Check the one of **highest** frequency.

Expected Frequencies
If the child is expecting to encounter health-related services in the near future, it may be difficult to determine the average frequency of help/services needed. With some conditions an educated estimate can be made. For example, if a child is expected to get a central line very soon it might be hard to predict the frequency of skilled tasks. However, since most central lines need to be flushed once/day, that is a safe box to check.

8.5 How long have the skilled nursing needs and health-related services ALREADY lasted?

This and the following question on the HRS page apply to the entire page of Health-Related Services (both tables). Consider any Medical or Skilled Nursing needs as well as any Health-Related Services checked above. If some have lasted longer than others, check the box that most accurately describes the need or service that has lasted the longest. Your options are (check only one option):

- Less than 6 months
- 6 months to 12 months
- More than 12 months from now

8.6 How long are the skilled nursing needs and health-related services EXPECTED to last?

This question applies to anything checked on the HRS page. See note from last question for further explanation. A child must need **long-term** support, not just short-term. Sometimes the duration of a child's health-related needs may be challenging for screeners to discover. Health care professionals routinely make predictions about health conditions and treatments and their expected duration. Hopefully they have explained this to the parents or it is documented somewhere. If the child has multiple tasks/conditions, focus on the one likely to last the longest. In other words, **only one (not all),** of the conditions needs to meet the duration requirement.

Less than 6 months – Check the box if:

- Child is expected to have surgery soon and to fully recover within several weeks after that.
- Child is in intensive care now but is expected to recover within a few weeks/months.
- Child is in total body cast but it is expected to be removed and activity resumed in about three months.
- Child has a temporary ostomy that is expected to be repaired within three months.

Less than 6 months – Do NOT check the box if:

- Child is waiting for an organ transplant.
- The child currently has a **tracheostomy, central line, TPN** or is on a **ventilator**, which is **expected to be removed** in less than 6 months. (Give the benefit of the doubt in case it takes longer than expected to wean the child from these life-sustaining treatments.)

6 to 12 months from now – Check the box if:

- The child currently has a **tracheostomy, central line, TPN** or is on a **ventilator**, which is expected to be removed in less than six months. (Give the benefit of the doubt in case it takes longer than expected to wean the child from these life-sustaining treatments.)

More than 12 months from now – Check the box if:

- Child is waiting for an organ transplant.
- Child is receiving PT, OT and ST through the school system and the IEP indicates the therapy will continue next year.

8.7 Unexpected Eligibility Determination for Medically Involved Children

If you complete a CLTS FS for a child in a fragile medical state and thought the child would meet the eligibility requirements for a particular program and they did not, contact state staff to discuss the outcome of the screen. This is especially important if medical intervention is pending eligibility for a particular program (e.g. Katie Beckett Medicaid Program). An example of such a child may be a child with recurrent cancer, a pending transplant but no current functional impairments. If this child's eligibility results indicated that they are not eligible for the Katie Beckett Program, please contact a state staff person to discuss the situation further.

MODULE #9: Risk

9.1 Risk Evident During Screening Process

The risk section of the CLTS-FS provides screeners an opportunity to note risk factors not captured elsewhere in the screen.

Newly discovered cases of abuse and/or neglect should in most instances result in a referral to APS for investigation, case planning and any necessary court related services. This module does not replace the function and process of the APS unit. **Screeners are expected to recognize signs of abuse or neglect and to know how to respond appropriately.**

Note that whether the parent is aware of and chooses a level of risk is irrelevant here. They may well choose to take the risk. But the screener is here indicating that, in her/his professional judgment, there is some risk. The screener then follows up in accord with her/his usual professional judgment.

In the Risk section, you will check any that apply. At least one box must be checked. Check “0” if no other fields apply, i.e., if there is no risk evident to screener.

MODULE #10: Functional Disability and Screen Completion Information

10.1 Functional Disability

The Functional Disability page is used when an individual appears to meet functional requirements for Social Security Administration (SSA) disability criteria. The disability logic considers functional screen data (age, ADLs/IADLs, cognition, etc.) in addition to data captured on the Functional Disability page. The Functional Disability Indicator (FDI) can only deduce "functional" disability and is only a recommendation for disability examiners. Examiners must consider other information such as applicants' current income and medical evidence. In 2005, the FDI will be in testing, including concurrent review by disability examiners. Some state and county processes may be revised based on the FDI's accuracy once testing is complete, but the final SSA disability determinations must continue to follow current SSA rules.

10.2 Screen Completion Date

The screen completion date is the date when all sections were completed by the certified screener, not the date information is entered into the computer. Indicate the date on which all sections of the CLTS-FS were complete. It may take more than one day to complete all sections, especially if a screener must wait for information from health care providers. It is acceptable for one person to enter the demographic information (module 2) and for the certified screener to complete the clinical entries (modules 3-9). However, all of the screen entry time should be combined and put under the certified screener's name.

10.3 Time to Complete Screen

Face-to-Face Contact with Child and Parent(s) or Guardian
This is the amount of time the screener spent face-to-face meeting with the child and/or their parent(s) or primary caregiver. Face-to-Face contact includes the entire time spent at a home visit with the immediate family even if the child is only seen for part of that visit. For example, if you are at the home for 1½ hours but the child was only present for the last 30 minutes, you would put 1hour, 30 minutes under Face-to-Face contact. Please round time to the nearest 15 minutes (00, 15, 30, 45).

Collateral Contacts
This is the amount of time the screener spent face-to-face meeting with collateral contacts (extended family members, teachers, therapists, health care providers, etc). And/or the amount of time the screener spent on the phone talking with collateral contacts. This includes phone conversations with the child's parent(s) or guardian. Do not include conversations with others who are present at a home visit. For example, if you are at the home visit and the child's teacher is also at the home visit, the entire time spent in the home is recorded as face-to-face contact not collateral contact. Please round time to the nearest 15 minutes (00, 15, 30, 45).

Paper Work
This is the amount of time the screener spent doing paperwork and paper research to complete the CLTS-FS. Phone contact with the parent or primary caregiver should be included in this category. Please round time to the nearest 15 minutes (00, 15, 30, 45). This does not include intake preparation.

Travel Time
This is the amount of time the screener spent traveling to and from appointments associated with the gathering of information necessary to complete the CLTS-FS. Please round time to the nearest 15 minutes (00, 15, 30, 45).

- Write all times as hours and minutes rounded to the nearest 15 minutes.
- The CLTS-FS application will sum them up for the total time.